Benin Integrated Family Health Program (PROSAF)

Annual Report

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Promotion Intégrée de Santé Familiale dans le Borgou et Alibori

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ACRONYMS

ABPF	*Association Béninoise pour la Promotion de la Famille*
AIDS	*Acquired Immuno Deficiency Syndrome*
AIMI	*Africa Integrated Malaria Initiative*
ATR	Administrative and Territorial Reforms
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior Change Communication
BINGOS	Benin Initiative for Non-Governmental Organization Strengthening
CA	Cooperating Agency
CADZS	*Cellule d'Appui au Dévelopment des Zones Sanitaires*
CAME	*Centrale d'Achat des Médicaments Essentiels*
CBS	Community Based Services
CBSA	Community Based Services Agents
CCS	*Centre Communal de Santé*
CDC	Center for Disease Control
CDEEP	*Comité Départementale d'Evaluation et Suivi des Projets*
CLUSA	Cooperative League of USA
COGEC	*Comité de Gestion de la Commune*
COGES	*Comité de Gestion de la Sous-Préfecture*
CODIR	*Comité de Direction*
CPR	Contraceptive Prevalence Rate
CVS	*Comité Villageois de Santé*
DDSP	*Direction Départementale de la Santé Publique*
DHS	Demographic and Health Survey
FP	Family planning
FPLM	Family Planning Logistic Management Project
GESCOM	*Projet de Gestion Communautaire*
GTZ	German Development Agency
HEPS	Health Education in Primary Schools
HIV	Human Immuno-Deficiency Virus
HW	Health workers
HZMT	Health zone management team (EEZ in French)
IEC	Information, Education and Communication
IGA	Income Generating Activities
IMCI	Integrated Management of Childhood Illness
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
KAP	Knowledge, Attitudes and Practices
MCH	Maternal and Child Health
MMC	Monthly Mean Consumption
MOH	Ministry of Health
MPA/N	Minimum Package of Activities for Nutrition
NGO	Non-Governmental Organization
ONG	*Organisations Non-Gouvernementales*
OSV Jordan	*Organisation Santé Vie* Jordan
PADS	*Programme d'Appui au Développement de la Santé*
PAMR	*Projet Pilote d'Appui au Développement Sanitaire*
PATH	Program for Appropriate Technology in Health
PBA / SSP	*Projet Benino-Allemand des Soins de Santé Primaires*
PBT	Preceding Birth Technique
PF	*Planification Familiale*
PHR	Partnerships for Health Reform
PROLIPO	*Programme de Lutte Intégrée contre le Paludisme dans l'Ouémé*

PROSAF	*Promotion Integrée de Santé Familiale dans le Borgou/Alibori*
PSI / ABMS	Population Service International / *Association Béninoise pour le Marketing Social*
PVO	Private Voluntary Organization
QA	Quality Assurance
ROBS/PAIR	*Réseau des ONG Beninois*
RPST	Rapid Problem Solving Team
SEPD	*Service des Etudes, Planification et Documentation*
SO	Strategic Objective
SONU	*Soins Obstétricaux et Néonatals d'Urgence*
SSF	*Service Santé Familiale*
STD	Sexually Transmitted Disease
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children Fund
URC	University Research Co., LLC
WHO	World Health Organization

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TABLES

1. EXECUTIVE SUMMARY

2001 has been a year of important accomplishments for the Benin Integrated Family Health Program (PROSAF). The groundwork laid during the first two years is beginning to yield positive, measurable results that will be described throughout this document. Equally important, however, is the change in attitude both on the part of the health care providers and on the part of the communities. Health facility personnel have begun to take more pride in their work, and to hold each other accountable to higher standards of care and teamwork. At the community level there is a much greater understanding of the health issues that men, women and children face every day and awareness that every individual has a role to play in improving the health of the community.

Much progress has been made in establishing an integrated approach to health service delivery. PROSAF has also worked intensively to link improvements in the system inputs (such as better trained personnel and equipment) to improved processes (such as supervision and clinical care) and to outputs. Important improvements have been achieved for some of the major health indicators. In the sections that follow, results are reported for each of the levels at which PROSAF works - the departmental health team, the zones, the health centers, the community organizations and the family. Major accomplishments are then listed by each of the five results packages. A summary of PROSAF's performance monitoring indicators, with results for each year, is also presented in Annex 1.

1.1. Description of Key Monitoring Indicators

Certain of PROSAF's performance monitoring indicators are intended to measure higher-level outcomes (based on USAID's Strategic Objective for health). Table 1 below lists results for the six higher-level indicators. All represent a positive change in health practices. It is important to note that data on knowledge and behaviors were collected using different sample size calculations in 2000 and 2001. What is important is the positive trends, rather than absolute comparisons.

TABLE 1: PROGRESS TO DATE IN KEY AREAS OF IMPACT

Indicator	1999	2000	2001[1]
Contraceptive prevalence	3%	7%	28%*
Couple years of protection[2]	6257	15089	17237
Exclusive breastfeeding	19%	52%	NA
Fully vaccinated	41%	37%	58%*
ORT utilization	29%	15%	50%*
Care seeking for fever	45%	49%	64%*

Sources: 1996 Demographic and Health Survey; Enquête sur les Connaissances, Attitudes et Pratiques in Matière de Santé Familiale (Borgou et Alibori), PROSAF, 2000; Focused Survey on Knowledge, Attitudes and Practices ("mini-KAP"), PROSAF, 2001

Increasing the use of modern methods of family planning has been a focus of PROSAF's interventions since the beginning of the project. The number of married women of reproductive age using a modern contraceptive method has increased by 300% in the past year (from 7% to 28%), at least in the concentration zones. Likewise, couple years of protection increased by 14%. Key interventions in the

[1] The 2001 figures marked with an asterisk (*) in this and the following tables come from a "mini-KAP" survey carried out only in PROSAF's concentration zones, and may not reflect changes in the department as a whole.
[2] The increase in CYP from 1999 to 2000 was due primarily to improved data collection. The calculation of CYP for 2000 and 2001 includes methods (Norplant and sterilization) and distribution points (including those of PSI) that were not included in the 1999 calculation. Thus, 2001 and 2000 data are fully comparable.

past year aimed at increasing CYP were improved counseling on family planning methods by health facility personnel, clinical training in specific methods (such as IUD insertion) the initiation of community-based distribution of contraceptives, and health messages disseminated by traditional media groups and on the radio. Qualitative research carried out in August allowed PROSAF to gather rich information about the population's perceptions of family planning services offered in the departments and their reasons for using or not using modern contraceptives. In general, obstacles to using services include financial reasons, fear of side effects, and lack of support by men. At almost all levels poor reception in health centers was cited as a major obstacle to care seeking and client satisfaction.

Child health is another area where impressive changes can be seen. In terms of preventive behaviors, PROSAF's support to the health system and communities has yielded a 57% increase in the proportion of children who are fully vaccinated before their first birthday (from 37% to 58%). This can be partially attributed to the work of the quality assurance teams functioning in four health centers of the Banikoara health zone. Some of the solutions that these teams implemented included an outreach strategy to vaccinate children in villages and increased information on the importance of vaccinations and potential side effects (fear of which is often a disincentive for mothers). In one community in the Banikoara health zone, the community has recruited a community agent who is devoted to outreach vaccination sessions. There, immunization coverage has reached 80%.

The rate of exclusive breastfeeding until four months was not measured by the Mini-KAP survey because of the large size of the sample needed, as well as the existence of recent data on this (from January 2001).

There has also been an improvement in treatment of sick children. The proportion of caretakers who administered oral rehydration therapy to a child with diarrhea increased to 50% in PROSAF's concentration zones. In addition, more people are taking their children to a health facility within 48 hours of the onset of a fever, or treating them at home with an approved antimalarial medication (up from 49% to 64%). PROSAF's work to influence these behavior changes include child health messages disseminated through popular and traditional media and one-on-one counseling by community-based service agents. Reacting to a cholera outbreak in the department, PROSAF supported the launching of radio awareness campaigns on cholera prevention using four community radio stations.

1.1.1. At the Level of Families and Communities

As shown in Table 1 above, there have been some major improvements in family and community-level health behaviors, e.g. increased use of modern family planning methods, ORT use and vaccination services, and exclusive breastfeeding of children up to four months. The work done by BASICS on exclusive breastfeeding has been extended by the CBSAs and traditional media in PROSAF's concentration zones. This has contributed, along with promotion by clinical workers in all health zones, to the significant increase in exclusive breastfeeding rates. This is jone example of an individual- and community-level change in behavior resulting from the multi-level education strategies used.

Knowledge levels on key family health topics have also increased, as seen in Table 2 below. Most of this progress was achieved through community-based health education and behavior change interventions carried out by community-based service agents and traditional media, as well as through increased broadcasting of effective and targeted radio health messages. PROSAF Community Facilitators and ABPF Zone Animators also carried out counseling and health education talks.

TABLE 2: PROGRESS TO DATE AT THE FAMILY/COMMUNITY LEVEL			
Indicator	**1999 (%)**	**2000 (%)**	**2001 (%)**
Knowledge of modern methods of family planning	5	6	28*
Knowledge of when to seek care for ARI	NA	66	91*
Knowledge of child diarrhea prevention	NA	69	48*
Knowledge of STI symptoms	NA	Women 6 Men 23	Women 38* Men 51*
Knowledge of methods to reduce risk of HIV infection	52	60	64*
Knowledge of malaria prevention	NA	55	29*
Community-based distribution and services	NA	11	30
CBSA home visits	NA	11	15*
Access to health messages	NA	Women 45 Men 62	Women 42* Men 55*

Knowledge of three or more modern contraceptive methods increased by an astounding 367% in the concentration zones, which clearly contributed to the significant increase in contraceptive use cited in Table 1. Women's knowledge of STI symptoms increased by 533%, while men's increased by 122%. This shows not just an overall increase but also the narrowing of the former marked sex differential. Knowledge of methods to reduce the risk of HIV/AIDS increased by 7%. These changes in knowledge about STI/HIV/AIDS prevention were translated into practice by some community members, as seen in the sales by CBSAs of more than 17,000 condoms this year.

Knowledge of ARI danger signs increased by 38%, but strangely the data shows a 30% decrease in knowledge of diarrhea prevention and a 47% decrease in knowledge of malaria prevention. This might be explained by lower levels of knowledge on diarrhea and malaria prevention in the concentration zones, whose figures are used for 2001, than in the department as a whole. In addition, there have not yet been any specific interventions on diarrhea or malaria prevention.

As seen in Table 2, by the end of the year community-based distribution and services were available in 30% of concentration zone villages, up from 11% in 2000. The 2001 mini-KAP survey also showed that 15% of the households surveyed had received a visit by a CBSA in the previous two weeks, which shows a high level of contact that has contributed to improved knowledge and practices. However, this survey also showed a slight decrease in the proportion of people who had heard a health message through any medium in the previous two weeks. This could be explained by the timing of health education campaigns.

Overall, families and communities in the Borgou and Alibori have higher levels of health knowledge and are adopting healthier behaviors. This may be attributed in part to the increase in information and services provided by the CBSAs, increasingly well-trained, equipped and client-friendly health workers, and the mass and traditional media health communications activities carried out by PROSAF and its partners.

1.1.2. At the Level of Community Organizations

Quarterly monitoring of COGEC/COGES performance allowed PROSAF to track the extent to which its capacity building efforts have produced results. The COGEC Performance Index measures the planning and management functions of the COGEC and is based on six criteria covering planning, implementation of activities, financial management, community awareness-building, inventory management and regular meetings. As seen in Table 3, 80% of COGEC in the concentration zones were functioning according to the given criteria in 2001, an increase of 14% over 2000.

TABLE 3: PROGRESS TO DATE AT THE COMMUNITY ORGANIZATION LEVEL

Indicator	1999 (%)	2000 (%)	2001 (%)
Performance index for COGEC	29	70	80
Performance index for CVS	NA	NA	39

The performance of village health committees (CVS) in the concentration zones is measured using the CVS Performance Index. This is based on the number of meetings held, implementation of planned activities, and action taken on problems raised by the CBSA. The CVS Performance Index could only be calculated in the third quarter of 2001 because of the delay in setting up community-based services, which are managed by the village health committees. CVSs are currently only active in the Banikoara health zone where CBSs are fully functional (Performance Index 53%). In Bèmbèrèkè/Sinendé activities have just started, resulting in a Performance Index of 26%. The overall achievement level is 39% for the CVSs in the two health zones. Nevertheless, this exceeds the 25% target for 2001.

PROSAF used skill-centered program to train COGEC, COGES and CVS members, along with a curriculum in three local languages, to achieve these results. Training sessions were organized in the villages with the full participation of village leaders. Two training sessions on two topics were attended by a total of 395 COGEC/COGES members. 186 COGEC members (including 19 health workers) were trained in their roles and responsibilities for the joint management of health centers. In addition, 209 COGEC/COGES members learned how to conduct effective meetings, write minutes and develop their internal regulations. These courses made COGEC/COGES members aware of the importance of their role and the need to perform it properly.

1.1.3. At the Level of Health Workers and Health Facilities

The key indicators at this level focus on the availability of integrated family health services and products, and health worker performance in certain clinical areas. PROSAF was not able to measure two of its key indicators in 2001 – health worker performance in integrated management of childhood illness (IMCI) and performance in family planning. IMCI has not yet been fully implemented in the departments, so the performance of health workers cannot be expected to have changed. As its rollout accelerates in 2002, however, improved performance is expected. Health worker performance in family planning could not be measured because there were no consultations observed in the course of supervision visits. This is explained by both the low utilization of this service, and because women often approach health workers for these services outside of clinic hours in order to maintain confidentiality in the face of conservative social attitudes. It is expected that PROSAF's support of community-based services (including family planning counseling) and behavior change activities targeting men will help increase the use of family planning services in 2002, and allow health worker performance to be evaluated.

TABLE 4: PROGRESS TO DATE AT THE HEALTH FACILITY LEVEL			
Indicator	**1999 (%)**	**2000 (%)**	**2001 (%)**
Family health products stock-out index	45	14	41
Prevalence of integrated family health services	12	24	57
Health worker performance index in prenatal care	0	NA	100
Health team performance index in quality assurance	0	0	100

The proportion of health facilities in the department without a stock-out of family health products during the previous quarter reached 41% by the end of the year. While this number is more than double the 2000 rate, it falls slightly short of the baseline figure. To address this persistent problem, PROSAF supported the work of rapid problem solving teams to identify of the main causes of stock-out in those facilities most frequently facing this situation. These include lack of financial resources due to incomplete implementation of cost-recovery and improper calculation of quantities to be ordered. Training on logistics management and supervision undertaken by the HZMT after this training contributed to the decrease in stock-outs.

The minimum package of integrated family health services is now being offered by 57% of public and private health centers, up from 24% in 2000. This increase can be attributed to the training of service providers using the integrated curriculum developed by PROSAF and the DDSP, as well as the program's provision of small medical equipment needed by service providers to perform their activities in an integrated manner.

The proportion of observed health workers who complied with essential prenatal care norms was measured at 100% in the third quarter of 2001 in the two concentration zones. This was the first time the indicator was measured, as zone teams were only trained on formative supervision techniques in the second quarter. Although the number of observations was low (only about 5% of all staff), this improvement can be attributed in part to the effort PROSAF has made to train health facility personnel in prenatal care service delivery based on the family health protocols, in addition to providing equipment such as scales, measuring tapes, blood pressure cuffs, gloves, and curtains to close off examination areas.

Although problem-solving teams were only established at the beginning of 2001, by the end of the year all of the teams in the concentration zones had become functional. The performance criteria for problem-solving teams include decisions being made by the team based on routine service data, all team members informed of planned activities, and problems being addressed using the team-based problem solving process. Eleven facility-based QA teams in the Sinendé/Bembèrèkè health zone are addressing the problem of low coverage of prenatal services, and ten teams in the Banikoara zone are addressing low rates of vaccination coverage.

1.1.4. At the Level of the Health Zone Management Teams

Performance of the health zone management teams (HZMT) is gauged by their ability to plan, to implement activities, and to supervise the health centers in their zones. As Table 5 shows, significant improvements have been made this year.

TABLE 5: PROGRESS TO DATE AT THE HEALTH ZONE LEVEL			
Indicator	**1999 (%)**	**2000 (%)**	**2001 (%)**
Health zone planning score	40	54	83
Performance index for health zone management team	0	26	36
Supervision system performance index	6.7	9	46

The Health Zone Planning Score reflects the proportion of all health zones in the departments that had operational plans in place during the current year. The score attained in 2001 was 83%, up from 54% in 2000. Some of the criteria for this indicator include current year plan developed before the start of the year, a financial plan negotiated with donors, and monitoring of current year plan occurring quarterly. PROSAF's work with the HZMTs this year has helped them to appreciate the importance of planning for the success of their activities, and to facilitate their work.

Overall HZMT management capacity is measured by a performance index that includes planning, implementation of planned activities, budget expenditures, the use of a health map, and formative supervision of health center staff. While this indicator increased by 38% over the 2000 score, it fell short of the 40% goal for the year. Difficulties in the development of health zone maps and the implementation of formative supervision can in part explain this. In addition, some Health Zone Coordinators have been assigned to other departments or left to further their education. The new Coordinators need time and training to understand the processes in place, which has contributed to the less than optimal performance of the zone teams.

The Supervision System Performance Index saw a significant increase this year, although training for HZMTs in formative supervision only began in the second quarter. Forty-six percent of health centers in the department received at least one supervision visit during the last quarter of the year. Performance is lower in the concentration zones due to the involvement of the HZMT in a series of training sessions, which prevented them from implementing formative supervision.

1.1.5. At the Level of the Departmental Health Service

TABLE 6: PROGRESS TO DATE AT THE DEPARTMENT LEVEL			
Indicator	**1999**	**2000**	**2001**
Family health product logistics management score	NA	Performance 34 (Sustainability 58)	Performance Bembèrèkè: 45 Sinendé: 46

Note: the 2000 score is for the Borgou/Alibori department as a whole. The 2001 score is only for the two given sub-prefectures, and only measures the "performance" component of the indicator.

In 2000 PROSAF used a family health product logistics management score developed by the Family Planning Logistics Management (FPLM) project. It evaluated the department's logistics system in terms of its performance and potential for sustainability. FPLM (now DELIVER) has since abandoned this indicator because it was considered to be too subjective. However, health centers in Sinendé and Bembèrèkè continued to use the "performance" section of the tool to evaluate individual health worker performance.

A key achievement of the year has been the resumption of weekly staff meetings and monthly planning meetings at the DDSP following their orientation in quality assurance. These meetings have enabled the DDSP to monitor activities included in the 2000-2002 strategic plan and management

plan, assess implementation levels, and seek solutions to problems encountered by the different Health Zone Management Teams. The DDSP has also worked closely with PROSAF and other partners to develop a "key indicator scoreboard" that will facilitate data collection and analysis by health facility staff.

1.2. Summary of Key PROSAF Results

1.2.1. Improved Health Planning and Coordination

- Draft plan to improve DDSP and HZMT management capabilities developed in conjunction with DDSP
- DDSP and all department heads familiarized with Quality Assurance approach centered around DDSP roles and functions; new management model is gradually being introduced by the DDSP
- Trainer's manual on HZMT supervision adopted, along with its template, as a model for other CADZS training modules
- Coaching provided to health workers from 21 CCSs in completing mid-course reviews of their action plans and budgets

1.2.2. Increased Access to Services

- 85 health workers trained to use family health product management tools
- 26 health centers equipped with medico-technical equipment and began providing the Minimum Package of Family Health Services
- technical and financial feasibility study conducted for the departmental family health product warehouse; funding commitments obtained from donors
- family health product stock created in the Banikoara health zone
- 350 CBSAs in the concentration and non-concentration zones provided with minimal equipment (case, backpack, mannequin, family planning IEC materials, essential drugs and/or contraceptives)
- community-based services introduced and strengthened in the concentration zones
- PROSAF community health worker curriculum adopted as the model for the national curriculum

1.2.3. Increased Capacity of Health Workers

- Development of IMCI implementation plan (2001-2002)
- Initiation of emergency obstetrical and neonatal care protocols
- Training of health workers in 23 CCSs to use FHS protocols and ten mentors to supervise these health workers
- Formation of departmental training team and development of training plan
- Training of 22 health workers in contraceptive technology in two health zones
- Training of nine mentors and 22 health workers in infection prevention in Banikoara health zone
- Formation and monitoring of 21 rapid problem solving teams
- Training of all HZMTs in formative supervision techniques

1.2.4. Increased Knowledge and Behaviors

- Adoption and implementation of BCC strategic plan
- Qualitative study of behaviors related to the low level of prenatal consultation, child vaccination and the use of contraceptives
- Development of 27 counseling cards, four brochures, and two posters as educational material for malaria prevention

- Training of 50 health and radio staff in the Borgou/Alibori on the "Role of radio in health promotion" and techniques for development and production of effective spots
- Assessment of activities and development of a program to broadcast family health messages over the radio in the Borgou/Alibori
- Dissemination of messages on family planning and ways to control childhood illnesses via popular and traditional media
- Pre-testing of two radio serials in French on family planning

1.2.5. Increased Community Involvement

- Involvement of COGECs and Village Health Committees (CVSs) in team-based rapid problem solving process at CCS level
- Training of CVS and Local Volunteer Committee (CLV) members in their roles and responsibilities, and conduct of effective meetings
- Training of COGEC and COGES members in roles and responsibilities and in conducting effective meetings
- Midpoint review of 2001 COGEC action plans and budgets jointly carried out by CCS and COGEC

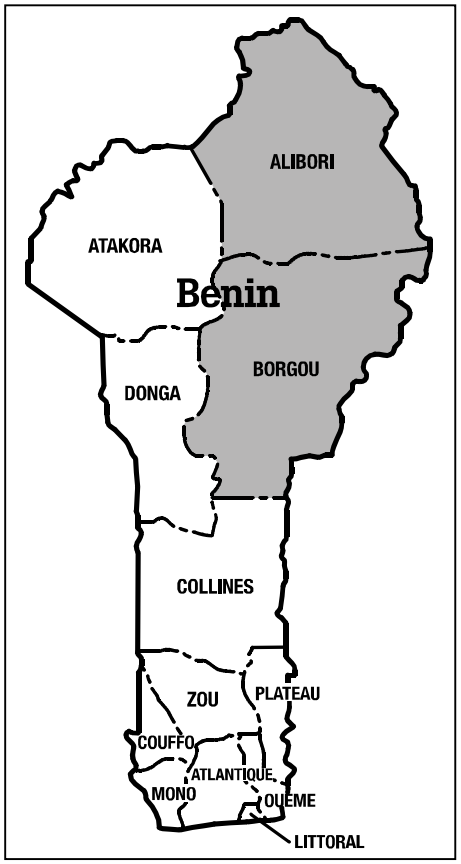
2. BACKGROUND AND APPROACHES

This section provides general background to PROSAF as well as a summary description of two approaches that underlie PROSAF's technical interventions. These are an integrated systems approach and quality assurance.

2.1. Background

USAID/Benin supports health and family planning activities in Benin with the goal of "increasing use of family health services and prevention measures within a supportive policy environment." The Benin Integrated Family Health Program, (PROSAF – Promotion Intégrée de Santé Familiale dans le Borgou et l'Alibori) actively supports USAID/Benin through a decentralized and integrated program of family health services in two health departments in Benin (Borgou and Alibori).

These departments in northern Benin cover almost half of the country's landmass and approximately 20% of its population (see map at right). They were chosen based on the severity of their health problems, the presence of an emerging private health sector, and the potential to integrate the program's health activities with USAID's activities in education, democracy, and governance in these departments.



PROSAF works closely with the Ministry of Health (MOH). PROSAF's activities directly support the MOH's priorities, namely family health, improved prevention and management of priority diseases, improved health services management through capacity building, and health zone development. Additionally, an important component of PROSAF's program focuses on the government's desire to strengthen the involvement of communities and the private sector in health care.

A consortium of four organizations implements PROSAF. University Research Co., LLC (URC) is the main contractor responsible for overall technical and administrative direction for PROSAF, and for managing a team of three subcontractors: the Association Béninoise pour la Promotion de la Famille (ABPF), the Cooperative League of the USA (CLUSA) and the Program for Appropriate Technology in Health (PATH). URC is responsible for improved health planning and coordination, improved access to integrated family health services and products, capacity building of health workers, and the development of health education materials. ABPF works to increase access to family health services and products in the program area, building on its experience in family planning and STI/HIV services throughout Benin. CLUSA provides expertise in innovative training and empowerment of community level organizations to participate in local health service management. PATH supports activities aimed at changing the behavior of providers and communities to achieve better health.

PROSAF works in the following five distinct, yet complementary, areas of family health service management:

1. Improved health planning and coordination. The focus of this management intervention is to help the department and the new health zones improve their planning processes and to strengthen coordination of activities among all programs and health centers.

2. Increased access to family health services (including family planning, maternal and child health, sexually transmitted diseases, and HIV). Communities need access to services in all components of family health at their health centers, and to be able to openly communicate, preferably in their own language, with health workers.

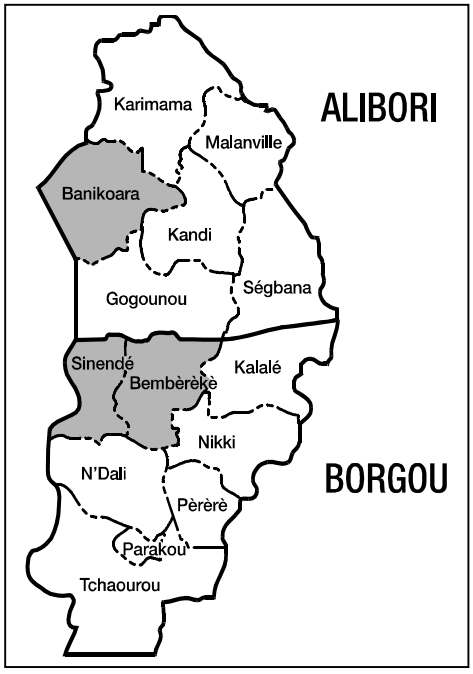
3. Increased capacity of health care workers to provide quality services. All health care workers need to be well trained and able to deliver the integrated package of health services according to the nationally established clinical guidelines. They also need to be able to monitor their own work and make ongoing improvements when necessary.

4. Increased knowledge and behaviors supporting the use of family health services, products, and prevention measures. Both communities and providers need to have the knowledge, information and materials necessary to make informed choices for care, and need to take responsibility for their own health behavior.

5. Increased public involvement in the planning and delivery of community-level health services and prevention measures in selected target areas. Health centers need to be actively supported by the families and community organizations that they serve. PROSAF aims to strengthen the ability of communities to take an active role in the delivery of health care services in their region.

The specific results that PROSAF is expected to achieve over the life of the project are summarized in Table 7 on page 11.

PROSAF works in all zones of Borgou and Alibori, but some activities are carried out more intensively in two health zones—Banikoara and Sinendé/Bembèrèkè (see map at right). This is particularly the case for work at the community level. Eleven Community Facilitators live in these two zones and work intensively with health facility staff, Commune and Sub-Prefecture Management Committees (COGEC/COGES), volunteer Community-Based Service Agents (CBSA), and community members.



2.2 Integrated Systems Approach

In order to achieve these five goals, PROSAF works to address them in an integrated manner at each level of the health system. The PROSAF team is proud to have established close working relationships with those who provide health services in the Borgou and Alibori and with the communities that use these services.

TABLE 7: SUMMARY OF PROSAF RESULTS PACKAGES AND OUTPUTS

RP 1: Improved health planning and coordination	**RP 2: Increased access to FP/MCH/STD/HIV services**	**RP 3: Increased capacity of health workers to provide quality services**	**RP 4: Increased knowledge and behaviors supporting use of FP/MCH/STD/ HIV services, products & prevention measures**	**RP 5:Increased community involvement in planning and delivery of community-level health service and prevention measures in selected target area**
OP 1.1: Develop and implement plan to increase capacity of Dept. and SP officials to plan and deliver health services	**OP 2.1:** Assist MOH to develop national logistics management system (with FPLM)	**OP 3.1:** Assist MOH to adapt and pilot test IMCI strategy in collaboration with BASICS	**OP 4.1:** Conduct formative and qualitative research to identify appropriate strategies and messages	**OP 5.1:** Work with BINGOs and others to develop selection criteria, and based on criteria, Identify 2-3 Sub-prefectures for BINGOs related NGO training
OP 1.2: Develop annual strategic and operational action plans, in collaboration with public, private and donor partners	**OP 2.2:** Improve supply and commodity distribution to and throughout Borgou, emphasizing family health commodities	**OP 3.2:** Assist MOH to expand role of midwives, including provision of emergency post-partum and neonatal care (PRIME)	**OP 4.2:** Develop and test specific materials and messages on FP themes using traditional media/ IEC	**OP 5.2:** Provide follow-up of other related results packages with selected health centers and communities (training/ IEC activities in family health, prevention)
OP 1.3: Improve data collection procedures for family health indicators	**OP 2.3:** Expand availability of integrated basic package of family health services	**OP 3.3:** Disseminate norms, standards and protocols of family health to health agents	**OP 4.3:** Include IEC and counseling in all in-service and pre-service training courses	**OP 5.3:** Identify training needs of COGES and COGEC and strengthen capacities to manage resources and be more involved in health prevention and outreach activities
OP 1.4: Review decentralization plans, make recommendations, and apply accepted policies and procedures	**OP 2.4:** Work with PSI and others to develop and implement strategy to increase community-level distribution of family health products	**OP 3.4:** Assess training needs of all types of health workers and develop training plan to meet needs	**OP 4.4:** In collaboration with BINGOs, HEPS and others, organize local NGOs to train social workers, ag extension agents in health IEC	**OP 5.4:** Recommend and finance sustainable community level interventions using innovative approaches to increase community participation
OP 1.5: Provide leadership for coordinated management of USAID funded activities		**OP 3.5:** Develop regional training team with skills to provide in-service training	**OP 4.5:** Include IEC activities in operational community-based development programs	
OP 1.6: Participate in development of work plans for field support projects to assure complementarity and coordination		**OP 3.6:** Develop creative ways to increase knowledge of health workers, including easy access and exchange of health info and techniques	**OP 4.6:** Develop and carry out a plan to increase capacity of health officials to develop, communicate and measure impact of IEC messages	
		OP 3.7: Assist DDS to develop formative supervision plan		
		OP 3.8: Develop reporting system to monitor training and performance of health workers		

In October 2000 PROSAF carried out an exercise to develop a vision that best reflects what the program strives to accomplish. The PROSAF vision for quality integrated services focuses on five distinct levels: the family and community, community organizations, health care providers and health centers, Health Zone Management Teams (HZMT), and the Departmental Directorate of Public Health (DDSP). Technical assistance is tailored to each level. At the family and household level, the focus of PROSAF assistance is on promoting healthy behaviors and community-based services. With community organizations, the emphasis is on mobilization and health education activities. Health worker and health center support focuses on training, supply and supervision. At the level of the Health Zone Management Teams and the Department, work is mostly directed towards improved planning and monitoring.

In addition to ensuring that all project components are addressed (e.g. planning and coordination, access, quality, knowledge and behavior, community mobilization), PROSAF focuses on capacity building at each level of the health system and better integration and collaboration between the levels. PROSAF has succeeded in establishing very close working relationships with all main partners working in health in Borgou and Alibori, as well as the central level Ministry of Health. PROSAF also works closely with other USAID-funded programs and other donor agencies to accelerate positive changes and develop systems that will be sustainable when donor funding ends.

PROSAF is an integrated family health project in every sense of the word. One of the project's primary objectives is to increase the availability and quality of integrated clinical services. In addition, PROSAF strives to help the health system work in an integrated manner, and models this by integrating the work carried out under its own five results packages. The following example describes how all of these efforts come together around the topic of family planning.

Improving Family Planning Services:
An Example of PROSAF's Integrated Approach

PROSAF has approached the problem of improving family planning services from several different angles at the *department level*. One of its primary tools has been the development of a training curriculum on integrated family health services (which includes modules on maternal health, interpersonal communication, and quality assurance). Members of the department health team train providers on quality services and assure follow-up through the improved formative supervision system. A key input to increase the use of family planning services is the availability of contraceptives. PROSAF has actively supported and guided the creation of a departmental warehouse for essential medicines and contraceptives, as well as the development of new tools for improved logistics management.

Many of the department level activities are replicated at the *zone level*, where there is greater focus on implementation. Using the results of various data collection activities supported by PROSAF (routine monitoring, KAP surveys, and qualitative research), several Health Zone Management Team (HZMT) have identified the low contraceptive prevalence rate as a priority problem and have included activities to address it in their annual action plans. HZMTs members have been trained to carry out formative supervision and give immediate feedback to improve provider performance through PROSAF's unique mentoring approach.

Health care providers and other clinic staff are central to efforts to improve the quality of family planning services and increase access to modern methods. PROSAF has made a significant investment in developing the capacity of health workers to increase access and quality. As part of the integrated family health package, doctors, nurses and midwives have been trained in contraceptive technology (oral contraception and barrier methods) and infection prevention. Recognizing, however, that clinical skills alone are insufficient to bring about change, PROSAF has also supported training in interpersonal communication and counseling skills to help health workers earn the trust and respect of their clients. As with the zones, low use of modern contraceptive methods was identified by health center quality assurance teams as a problem and is being prioritized.

Community organizations such as commune health center management committees and village health committees have been supported by PROSAF to take a greater role in the organization of services at their local health centers, thereby contributing to the availability of family planning services. Village health committees are responsible for assuring the supply of contraceptives and other family health products to community-based service agents (CBSA). They also participate in supervision of the CBSA and problem-solving meetings with the community. PROSAF has also drawn on the influence of community leaders with positive attitudes toward family planning to support its work at the grassroots level.

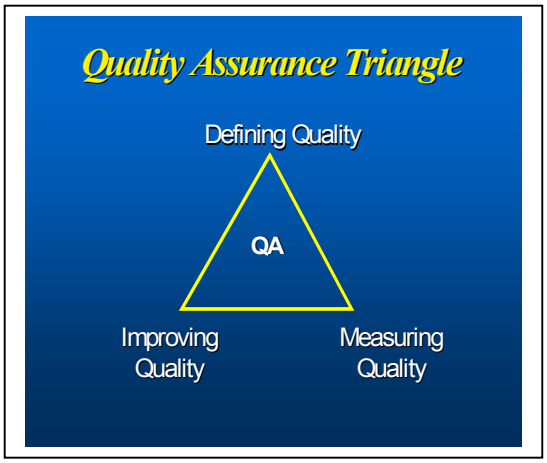
While PROSAF's interventions at the other levels focus on improving access to quality services, the emphasis at the *family/community level* is on behavior change – i.e. increasing demand for family planning. Popular and traditional media (such as theater and musical groups) have developed and disseminated messages on the benefits of birth spacing and smaller, healthier families. Local radio station staff have been trained to produce more effective and accurate family planning promotional spots, and they have also been successfully used to inform the population about clinic hours and the availability of services. Finally, CBSA provide group health education and one-on-one counseling to individuals on the various modern contraceptive methods and potential side effects, and sell condoms, spermicides and oral contraceptives.

The synergistic effect of PROSAF's different (yet integrated) interventions at all levels can be seen in the increased contraceptive prevalence rate and couple years of protection measured during 2001. Continued work in the coming year will likely yield more benefits for both the health system and the population.

2.3. The Use of Quality Assurance to Improve Health Systems and Services

Quality assurance (QA) is an important component of PROSAF's approach to improving the quality, access and utilization of health care. Quality assurance includes all actions taken to make health care better. It is not viewed as a separate program or a set of separate actions working independently. Rather, the goal of QA is to be integrated into all programs and activities and to create a culture of quality in the health system and among communities. To instill such a culture in the Borgou and Alibori, PROSAF activities are based upon four main QA principles. These are the importance of client perspectives and needs, an understanding of health care as processes and systems, the use of data to test changes and to make decisions, and teamwork. The principles are being introduced at all levels where PROSAF works, from the communities to the departmental management team.

To improve health service performance, QA encompasses three core groups of activities: defining quality, measuring quality and improving quality. The triangle at right illustrates the mutually supportive nature of these sets of QA activities. Depending on the specific level in the system for which technical assistance is provided, different QA activities are being supported. It is important to note that the QA Triangle does not purport a "correct" or even optimal entry point for initiating QA activities; one does not have to start by setting standards. The needs identified through the management and quality of care assessment provided the entry point for the design of QA interventions.



The focus of PROSAF is to improve the integrated management of childhood illnesses and to improve the health of mothers. The following table presents PROSAF's main activities by each of the three sets of QA activities. When appropriate, reference is made to the specific level of the system targeted. Much support exists for the QA approach, which is leading to systematic and far-reaching transformation of the attitudes and practices of health workers and communities alike. The challenge in the years ahead is to solidify the accomplishments and to move the organization towards incorporating the principles of QA into all its programs and activities so that the ability to produce quality health care and continuously improve is fully institutionalized.

QA Activity	Activities Undertaken
Defining Quality	♦ Participate in the development of standards for obstetrical care ♦ Participate in the adaptation of IMCI protocol to local conditions ♦ Developed guidelines for logistics management ♦ Developed guidelines for management of DDSP team ♦ Define roles and responsibilities of community-based health workers
Measuring Quality	♦ Developed integrated supervision checklist ♦ Assist with the development of Health score card ♦ Train communities to collect and analyze health data ♦ Work with health centers to use data to identify problems and to measure improvement ♦ Assistance with improvement of SNIGS
Improving Quality	♦ Form and support problem solving teams of communities and health centers ♦ Train in new standards, using integrated training curriculum ♦ Train health workers in local languages to improve communication with client ♦ Develop user-friendly client and provider job aids in local languages

3. PERFORMANCE REVIEW AND ANALYSIS

The PROSAF 2001 Annual Report documents and summarizes program progress and major technical activities during the year, according to PROSAF's five Results Packages and their associated outputs. The major accomplishments of each Results Package are presented in a table in Annex 2 to show how they contribute specifically to USAID/Benin's Intermediate Results. Quotes from PROSAF's partners at all levels are interspersed throughout the report, highlighting the impact of some of the activities implemented during the year. Challenges and opportunities that have been encountered are also presented at the end of the report.

3.1. Results Package 1: Improved Health Planning and Coordination

PROSAF, through its first Results Package: *Improved Health Planning and Coordination,* provides support to USAID's Intermediate Result 1, *Improved Policy Environment*. Through the activities of this Results Package, PROSAF works to improve public and private sector health planning and coordination at all levels in the two program departments; to reinforce the management capacity of health personnel and their use of data for decision making; and to support coordination with other USAID-funded projects.

PROSAF has been active in providing technical assistance to strengthen health planning at departmental, zonal and community levels. One essential strategy has been the introduction of quality assurance (QA) and team-based management. Quality assurance has been part of all of PROSAF's work. Some of the essential principles of QA, the participatory nature of the processes used to build consensus for the reinforcement of management and support systems and the attention given to improving data collection and analysis, are particularly relevant for PROSAF's work with the departmental and zonal management teams. While quality assurance principles have been introduced to all zones and the department, PROSAF has concentrated its efforts to strengthen the use of QA methods in its concentration zones.

Primary Accomplishments

- Draft plan to improve DDSP and HZMT management capabilities developed in conjunction with DDSP
- DDSP and all department heads familiarized with Quality Assurance approach centered around DDSP roles and functions; new management model is gradually being introduced by the DDSP
- Trainer's manual on HZMT supervision adopted, along with its template, as a model for other CADZS training modules
- Coaching provided to health workers from 21 CCSs in completing mid-course reviews of their action plans and budgets

3.1.1. Capacity Building for Health Service Planning and Delivery

This year PROSAF and the DDSP produced a management capacity development plan that details the program's approach and specific activities being carried out. The management capacity development plan serves as both a working tool and a reference document. Strengthening the management system in

Borgou and Alibori is based upon the view of the health structure as a system (see Annex 3 for an outline of the plan). The main steps that are being followed - assessing needs, planning, implementing and monitoring and evaluating impact - are the same for all the management subsystems. What is particularly important in this plan, however, is the agreement reached with health managers in the department and the zones, that a very important objective of the management plan is to install a culture of quality among all providers and managers. It is anticipated that such a culture will lead to better collaboration, more openness of communication and a willingness to continuously improve. To reach this objective of a culture of quality, assistance is being provided in:

- Team work
- Respect of management norms
- Strengthening monitoring mechanisms
- Acceptance of and responsibility for results
- Use of problem solving techniques
- Application of coaching techniques and facilitate the management of change among the teams

PROSAF Systems	
Health services	**Management services**
Prenatal care	Planning
Post natal	Coordination
Well-child	Information
Vaccinations	Logistics/supply
Nutrition	Clinical/service organization
Curative care	Training
Family planning	Supervision
Nutrition	BCC/IEC
Birthing	Human resources
	Financial
	Community participation

Specific results to demonstrate improved capacity to plan and implement are as follows:

TABLE 8: PROGRESS ACHIEVED IN CAPACITY BUILDING FOR HEALTH SERVICE PLANNING AND DELIVERY AT THE ZONE LEVEL

Performance indicators	**4th Quarter 2000**	**1st Quarter 2001**	**2nd Quarter 2001**	**3rd Quarter 2001**	**Observation**
Health Zone Planning Score	54%	-	-	83%	Measured annually
HZMT Performance	26%	29%	44%	36%	Measured quarterly

The Health Zone Planning Score reflects the proportion of all health zones in the departments that had operational plans in place during the current year. The score attained in 2001 was 83%, an increase from 54% in 2000 (and surpassing the objective of 75% for this year). Some of the criteria for this indicator include current year plan developed before the start of the year, a financial plan negotiated with donors, and monitoring of current year plan occurring quarterly. PROSAF's work with the HZMTs this year has helped them to gain a very good understanding of the relevance of strategic and annual plans, and of the need to negotiate financing with partners for implementation of planned activities.

Health Zone Management Team Performance is progressing more slowly. This is due to the difficulties encountered in developing health maps and in carrying out formative supervision on a regular basis. A further factor that hindered more rapid progress is the departure of several HZ Coordinators: some left for advanced training in Public Health, others were reassigned to another Department. Despite these constraints, the performance level for the Health Zone Management Teams in the 3rd quarter of 2001 is fairly close to the objective set for 2001 (40%).

The challenges facing the DDSP is to continue to strengthen the capacity of the HZMTs to provide better management and supervision support based upon the plans that they have developed.

Central Level PROSAF has provided important support to CADZS. CADZS provides guidance and training support to the zones, and assists them in becoming functional decentralized management units. CADZS has been developing training modules focused on management capacity and health policy issues. CADZS has looked for PROSAF to provide guidance on the use of adult education training methodology for in-service training. In particular, the training module on supervision produced by PROSAF was adopted by CADZS both for its content and as a model for other training modules.

The expansion of quality assurance knowledge and application in the Borgou and Alibori continues to provide motivation of the implementation of the National Quality Assurance Program which the Ministry of Health has adopted. Priority focus of the program is to implement QA in health zones and hospitals. This program includes:

- implementing the program at all levels with a simple structure integrated into the DDSP and Zone teams;
- training health workers in Quality Assurance techniques,
- communicating standards and disseminating results of quality improvement efforts; and
- giving priority to monitoring activities.

The newly formed nursing and obstetrical care department in the Ministry of Health has been designated to spearhead QA activities in the hospitals. The national QA coordinator was promoted to Director of Family Health. The Minister of Health appointed a Special QA Advisor to her cabinet.

PROSAF has continued to help the Ministry of Health devise strategies for implementing the decentralized health policy by attending national workshops, such as the one to amend the plan for the national Quality Assurance program and the one to validate training modules to strengthen HZMTs.

Intermediate Level A breakthrough working session with DDSP staff has led the DDSP to reorganize the way it works and to adopt new coordinating mechanisms that allow for more active involvement of members of the DDSP staff. Specifically, weekly staff meetings are being implemented and formalized; administrative and management standards are being revised, disseminated applied in all departments of the DDSP; roles and responsibilities have been defined with regard to oversight and support of the DDSP departments of QA activities being carried out in the health zones. The weekly DDSP staff meeting now includes not only DDSP staff, but also other partners such as PBA and BASICS. This regular forum will allow ongoing coordination between DDSP departments and partners and sharing of both problems and solutions.

The quarterly expanded CODIR meeting, which includes zone medical officers, is another coordination mechanism supported by PROSAF. This framework enables the DDSP to ensure the consistency and integration of its action plan developed with the partners with those of the zones. The expanded CODIR brings together all DDSP department heads, zone medical officers and partners to report on the status of activities, plan for the next quarter and discuss results and supervision/monitoring activities. This year was the first time that these quarterly meetings were held.

These meetings have been very instructive for PROSAF to plan targeted technical assistance to help with better use of data to support observations and decisions. Other important impediments to optimal coordination among the zones and the department are the lack of qualified staff, difficulty in communication due to the lack of a aerial communication network (RAC), continued interference from the central level and partners making it difficult to maintain programming.

A further hindrance to the development of the zones is the ineffectiveness of decentralization in the country. PROSAF produced a working document on health zone development that will be used as a reference to support the DDSP and its partners in the HZs.

IMCI implementation in the Borgou/Alibori provided a concrete opportunity to transfer management and planning skills to the DDSP team and health zone medical officers. DDSP staff was involved in all stages of the process: definition of consultant's terms of reference, conceptualization of strategies for integrating the three components into zone activities, design of workshop content and program, and facilitation of discussions during the workshop.

3.1.2. Improving Data Collection Procedures for Family Health Indicators

Development of Indicator Scoreboards During the past year the focus of PROSAF's effort to improve the collection of routine data has been to integrate the collection of several important indicators into the overall data collection process of the department. PROSAF initially worked on identifying and collecting data that seemed to be missing, such as quality indicators for the provision of care, performance of the zone and community structures in their planning and management, and the supply and distribution of drugs. These omissions had been identified in the initial management assessment in 1999. As PROSAF worked with the health centers and zones this past year, they recognized more and more their need for data to plan and manage, and indicators that would help them more regularly assess and correct actions for better results. At the end of 2000 the DDSP, zone coordinators and partners instituted a committee to examine improvements that might be made for the collection and use of data by health workers and managers. The committee was charged with two principal tasks:

1. to propose indicators that would better measure effectiveness of management and supervision activities and the quality of care, and
2. to propose a « scoreboard » (*tableau de bord,* in French) of the key indicators to be monitored at each level of the health care system.

Underlying the expressed tasks for this committee was the desire of zone coordinators in particular to know how to better analyze data, and how to use the data for the management of their zones. The committee did not need to re-design the information system, as Benin has an internationally recognized system that looks at service statistics and some management data related to cost recovery activities. However, the analysis of indicators at any level of the system is perfunctory and serious problems are not identified until the effects of system dysfunction are critical or alternate systems have developed.

An additional problem was the fact that each health sector partner has his own set of program indicators specific to the interventions being supported that they needed to have collected regularly. While each partner has tried to use the routine health information system indicators, some are not specific enough and timeliness of data collection and analysis is often a problem (in terms of reporting results to funding agencies). The result has been parallel data collection processes that often confuse and overburden the health workers who must provide the data. Many health workers simply fill in forms with numbers as they see fit, and have not had the opportunity to understand the figures or how they might be used to improve their own work.

The committee charged with making proposals to improve the collection and analysis of routine data looked at all of the indicators from the various sources and chose a minimum set of indicators for each

level of the health care system, with the exception of the community and DDSP levels. These indicators were compiled into scoreboards that were presented to the department health system managers and zone coordinators in June 2001. The scoreboard is a tool to assist health personnel at all levels to monitor key indicators for which they are responsible. Indicators are calculated on a quarterly basis, except where specified otherwise. The data will be plotted on graphs to visualize trends and to compare results across different health centers, zones and eventually departments. It is anticipated that the use and graphic representation of fewer indicators and on a more regular basis will promote a culture of results orientation and continuous improvement.

To date, the consensus has been developed around indicators at the CCS level, at the zone level and at the zone hospital level. The performance indicators at the DDSP level that were introduced with the 2000 – 2002 strategic plan have yet to be re-examined and re-negotiated**.** Targets for each indicator also remain to be finalized. Annex 4 shows the indicators chosen and proposed for the scoreboard at each level.

Logistics of Data Monitoring PROSAF provided twenty computers and printers as well as computer accessories to the HZMTs and the DDSP to help them better manage their activities in general, and specifically, strengthen their use of data for decision making. In addition to the equipment provided, PROSAF has supported the development of new data collection forms to complete the LOGISNIS, a software program used to manage data collected through the national health information system. PROSAF has also supported training of DDSP and HZMT personnel in the use of computers and the LOGISNIS forms. As described in the box at right, the DDS took a stance for an appropriate use of the equipment provided.

> At one of its meetings, the rational use of the computers provided by PROSAF was discussed, along with the involvement of division heads in activities conducted by department heads. DDSP Staff decided that PROSAF would help the DDSP set up a computer room where all desktop computers supplied by PROSAF would be available for use by both DDSP staff and HZMT staff passing through Parakou. Accordingly, the computers will not be considered the "private property" of the department heads, but are to be used as shared tools for improving performance and productivity. PROSAF will further support the DDSP by also setting up the Study, Planning and Documentation Department (SEPD) documentation unit. The goal is to strengthen DDSP capacity so it also becomes a place to research, document, analyze and exploit data for planning and decision-making.

One of the obstacles identified last year to improving data collection, analysis and utilization at the department level was a lack of personnel. The MOH has provided additional staff to the DDSP though not specifically for data management tasks. The DDSP judged that the additional human resources could be deployed to alleviate the burden on the SEPD. PROSAF has thus supported the DDSP to better reorganize this changing staff and the changing role of the DDSP in the management of its data collection and analysis system.

Another longer-term effort to engage the DDSP in the task of analyzing data for evaluating results is to promote the use of Internet technology to link the various users of the health system. By creating linked health data bases and making them accessible through a regionally-based Website, routine, periodic and research data will become accessible on an ongoing basis. This strategy will be implemented in conjunction with the other partners in the next year.

Data Collection on Community Knowledge, Attitudes and Practices In addition to supporting routine data collection procedures, PROSAF carried out a focused survey of knowledge, attitudes and practices (called a “mini-KAP” survey) in the two concentration zones and one control sub-prefecture. Data provided by this mini-KAP complements service statistics by monitoring changes in the community. This survey follows on a complete KAP survey carried out across the Borgou and Alibori

departments in 2000. It was developed with substantial input from the DDSP. Community-based service agents served as data collectors and surveyed 1200 households. They were supervised by PROSAF Community Facilitators. The mini-KAP survey findings provide an indication of PROSAF's progress in the concentration zones, and a comparison to the situation in a non-concentration area. Preliminary results of the survey are discussed under Results Package 4.

3.1.3. Decentralization

During 2001 PROSAF continued to work at two levels to assist with the implementation of decentralization: 1) health zone development and management, and 2) re-energizing of community health committees for the co-management of their health centers.

PROSAF provided support to the CADZS in the development of training curricula in health zone management. In addition, the program has helped the CADZS define functional criteria for health zones and the description of responsibilities for each level. These criteria are based on the essential functions of a zone, namely health planning and policy, resource management, information management, logistics, support to community health activities, supervision, coordination, and quality control. For each function, the level of responsibility of the Zones was determined, and clear boundaries established with the department and the health centers. Norms for each function were developed and indicators to measure performance in each function, as well as data verification sources, proposed.

All Health Zone Management Teams were trained in formative supervision. This is a very important achievement and instrumental in strengthening their management and oversight capacity in establishing a culture of quality within their management practices. Formative supervision is described in detail under Results Package 3.

At the community level, PROSAF trained community health management committees (COGEC) in meeting management and problem solving techniques to facilitate decision-making. A second important activity was support to the COGEC in the evaluation of their annual work plans and budgets, and analysis of progress and obstacles. The results of these analyses show that a health facility activity planning and budgeting model with local participation has taken form (see RP 5).

The facility activity planning and budgeting done with community participation is very important. It is through this process that COGEC members can fully play their role in health center management. The review of progress to date further allowed COGEC members to become familiar with their roles in planning, monitoring, and evaluation of activities. It also assured transparency in the management of health center resources. As health center personnel and COGEC members must continually account for their joint management, they will be forced to be rigorous and transparent in their practices. The next step will be to assist with the continued implementation of the work plans, and to work towards fully institutionalizing this management model by repeating the review process until it becomes a reflex.

3.1.4. Leadership for Coordinated Management and Work Planning

PROSAF continued collaborating with the partners working in the Borgou/Alibori both directly and through DDSP staff meetings. Collaboration this year partly took the form of "technician exchanges", which made it easier for everyone to do their jobs without resorting to outside consultants. PROSAF

also invited staff from other partners to participate in its training programs. USAID organized a new form of collaboration among its partners through a joint planning session.

Collaboration with DELIVER (formerly FPLM) This year, collaboration with DELIVER was marked by PROSAF's participation in the National Advocacy Workshop to Guarantee Product Availability, particularly contraceptive products, organized by DELIVER and the DFH/MOH. The goal of the workshop was to familiarize participants with the advocacy approach for mobilizing resources to ensure product availability. During the workshop, DELIVER and PROSAF representatives both supported the adoption of an integrated logistics system for contraceptives, essential drugs and other family health products to guarantee availability. This integrated system will be implemented in the Borgou and Alibori.

Collaboration with BASICS Activities supported by BASICS through the end of August had focused on the training of 3000 community volunteers in nutrition. Discussions were held in the second quarter with the BASICS team and the DDSP concerning the continuation of nutrition activities and how PROSAF could support them after September 2001. In light of the MOH's adoption of a national IMCI strategy and the designation of the Borgou as one of the main sites for implementation of IMCI, it was decided to integrate the support to nutrition in an integrated community-IMCI strategy. The development of the community-IMCI strategy was developed as part of the overall IMCI strategy for the department and was achieved with technical support from the BASICS regional office.

Collaboration with PRIME During this year, close collaboration with PRIME focused on the development of a training strategy and introduction of the mentoring approach for improving the performance of health workers in the use of family health protocols. The step-wise training strategy involves on the job mentoring and coaching, followed by focused supervision.

A meeting was held on SONU community interventions between PROSAF, PRIME and PBA to identify ways of collaborating on community SONU in Malanville. It was decided that PROSAF would fund community organization and training activities and, especially, provide technical support for interventions for a community partnership. Another concrete outcome of this meeting was the preparation of an agenda for SONU implementation in Malanville.

The results of this collaboration are detailed in Results Package 3.

Collaboration with Africare PROSAF's collaboration with Africare, through their Ouémé Child Survival and PROLIPO/AIMI projects *(Programme de Lutte Intégrée contre le Paludisme dans l'Ouémé/*Africa Integrated Malaria Initiative) has been mutually helpful. PROSAF invited PROLIPO to participate in its work with the National Malaria Control Program to develop educational materials on malaria prevention and treatment. PROSAF has benefited from the experience and technical assistance of PROLIPO, particularly training materials and trainers, in developing its IMCI implementation strategy for the Borgou/Alibori.

Collaboration with PSI PROSAF has devised behavior change communication strategies to complement activities in the social marketing of family health products led by PSI. In addition, data and information on sales and sales points have been shared, and PSI collaborated on the development of malaria educational materials. In the coming year, PROSAF will work with PSI to plan concrete activities for the field to strengthen collaboration.

Collaboration with the MOH and Other Donors PROSAF attended numerous meetings at the central level in 2001. Such participation is important as many of PROSAF's interventions can only be carried out with full support of the central level. Furthermore, the Ministry plays a key role in the implementation of the decentralized health management model through the Zones. At the same token, the Ministry has been very interested and receptive to adopt some of the innovative strategies introduced by PROSAF, such as the use of adult education methods for training and QA.

PROSAF attended the second SONU meeting at the Family Health Directorate (DSF) in Cotonou. A SONU division has been created in the DSF since the first meeting last year. The composition of the steering committee was reviewed and expanded to include a midwife and several members to representate the community perspective. An ad hoc committee was set up to rule on the steering committee's attributes, roles and responsibilities.

PROSAF provided leadership in bring together all stakeholders and users of health promotion materials. The goal was to obtain a commitment from partners to co-finance the production of the printed materials for malaria prevention. After a brief review of the process followed to create the materials, 27 images with accompanying text and the pretest results were presented and discussed. Agreement was reached to produce the same materials and pool financial resources. The new experience introduced by PROSAF was hailed for its use of modern technology (digital photography and graphics software). This activity is further described under Results Package 4.

PROSAF attended the restitution meeting on field visits made by the MOH committee that monitors USAID-funded programs, also attended by the Minster of Health and the Director of USAID in Benin. Recommendations touched on solving problems with per diem, the supply of essential drugs, contraceptives and vaccines, strengthening supervision and monitoring to guarantee success, and introducing a mechanism to ensure sustainability in all programs. A comment was also made about the lack of human resources in the Borgou/Alibori DDSP.

Collaboration with UNICEF PROSAF has maintained close contact with UNICEF to coordinate the interventions. One activity was the departmental dissemination workshop on the results of the National Vitamin A and Iodized Salt Survey. This survey, which was carried out with UNICEF's support in June 1999, concluded that the prevalence of vitamin A deficiency is relatively high in the Borgou/Alibori, in spite of fairly high coverage of vitamin A supplementation. Strategies were suggested to improve the situation such as intensified IEC activities, implementation of IMCI, and intersectoral collaboration. The community-IMCI work supported by PROSAF is busing the results of this survey to plan its interventions.

A second joint activity was the zone workshop in Sinendé/Bembèrèkè facilitated by the Zone Medical Coordinator. plans and budgets were discussed and adopted for 11 CCS, the zone hospital and the HZMT in the course of a very participatory process, Participants in the workshop included HZMT members, and the head nurse, midwife and COGEC president from each health facility. PROSAF Community Facilitators provided technical and logistical support to the workshop. At the end of the workshop, one head nurse noted that he was very impressed by all these people working together, and particularly to see the COGEC presidents present and defend their own plans.

3.2. Results Package 2: Increased Access to Family Planning, Maternal Child Health And Sexually Transmitted Diseases/Human Immunodeficiency Virus Services

PROSAF's Results Package 2*: Increased Access to Family Planning, Maternal Child Health and Sexually Transmitted Diseases/Human Immunodeficiency Virus Services,* directly supports USAID's Intermediate Result 2, *Increased Access to Family Health Services and Products.*

During this year, PROSAF helped increase access to quality family health services by focusing on:

- training health care workers to manage the logistics of family health products
- applying the team-based rapid problem solving technique to the problem of frequent stock outs
- making more family health products available by helping implement a zonal stock for the Banikoara zone
- supplying health centers with small medico-technical equipment
- continued development and strengthening of community based services (CBS) through village health worker training and equipping them with limited drugs and contraceptives

In addition, PROSAF followed up on the MOH plan to build a decentralized warehouse for drug and contraceptive supplies for the Borgou and Alibori.

Primary Accomplishments

- 85 health workers trained to use family health product management tools
- 26 health centers equipped with medico-technical equipment and began providing the Minimum Package of Family Health Services
- technical and financial feasibility study conducted for the departmental family health product warehouse; funding commitments obtained from donors
- family health product stock created in the Banikoara health zone
- 350 CBSAs in the concentration and non-concentration zones provided with minimal equipment (case, backpack, mannequin, family planning IEC materials, essential drugs and/or contraceptives)
- community-based services introduced and strengthened in the concentration zones
- PROSAF community health worker curriculum adopted as the model for the national curriculum

3.2.1. Strengthening the National Logistics Management System and Improving Distribution in the Borgou/Alibori

In 2000 PROSAF used a family health product logistics management score developed by the Family Planning Logistics Management (FPLM) project. It evaluated the department's logistics system in terms of its performance and potential for sustainability. FPLM (now DELIVER) has since abandoned this indicator because it was considered to be too subjective. However, health centers in Sinendé and Bembèrèkè continued to use the "performance" section of the tool to evaluate individual health worker performance in terms of compliance with logistics management standards. The table below shows performance results for Sinendé and Bembèrèkè, for 2000 and 2001.

TABLE 9: PROGRESS ACHIEVED IN LOGISTICS MANAGEMENT FOR BEMBEREKE AND SINENDE		
Sub-Prefecture	**2000**	**2001**
Bembèrèkè	39%	45%
Sinendé	53%	46%

Clearly, logistics management in Bembèrèkè improved but in Sinendé it deteriorated. Part of the reason for the worsening situation in Sinendé may be due to the prolonged absence Chief Medical Officer for this sub-prefecture due to training.

The proportion of health centers without stock outs of family health products in the last three months rose from 14% at the end of 2000 to 41% in the third quarter of 2001. This is very encouraging. Nevertheless, quarterly data (see Table 10 below) show that stock outs do occur frequently, and that there is no consistent improvement in stock-out reduction among health centers throughout the year. This would indicate that logistics management and supervision activities alone are unable to solve the stock out problem in the Borgou/Alibori. The Ministry of Health must, through the Essential Drugs Purchasing Center (CAME), quickly implement the departmental warehouse so that family health products can be restocked on a regular, ongoing basis and be available for health centers when they need them.

TABLE 10 : PROGRESS ACHIEVED IN REDUCING STOCK-OUTS OF FAMILY HEALTH PRODUCTS					
Performance Indicator	**4th Quarter 2000**	**1st Quarter 2001**	**2nd Quarter 2001**	**3rd Quarter 2001**	**Observation**
Family Health Products Stock-out Index	14%	38%	23%	41%	Measured quarterly

Until the warehouse is built, PROSAF will continue to help the DDSP and HMZTs find best-fit solutions to significantly reduce stock outs. To do so, the rapid problem solving technique was used to address the stock out problem. This technique is one of the QA tools used to address problems identified during routine data analysis. The process involves analyzing the problem in a team, identifying possible solution, implementing the solutions and measuring results. This technique was introduced in selected CCS. The analysis and solution development was done together with CCS staff and COGEC members. The table below shows the causes identified and solutions proposed following these discussions in the health centers of the Nikki-Kalalé-Péréré zone, used as an example.

TABLE 11: RESULTS OF RAPID PROBLEM SOLVING PROCESS TO REDUCE STOCK-OUTS IN NIKKI/KALALÉ/PÉRÉRÉ	
CAUSES	**SOLUTIONS**
1. Lack of money in some CCSs to order drugs; poor ability to collect debts from patients cared for on credit; low utilization of CCSs.	Create a debt collection committee whose membership includes local leaders
2. Poor management of family health products. Quantities ordered rarely take into account the mean monthly consumption of the products, the available usable stock and the maximum stock. Consequently, CCS orders fail to cover its needs and result in stock outs two to three weeks after the products are received. Moreover, neither the sub-prefecture nor the zone level controls orders made by the CCSs under their responsibility.	Train/retrain health workers on site to correctly estimate product order sizes based on mean monthly consumption
3. The sub-prefecture health team feels no responsibility for product availability in the CCSs it supervises. When CCSs report supply problems, the sub-prefecture team rarely looks at them, leaving	Implement monthly supervision of CCSs with frequent stock outs and give them the necessary support

the CCSs to work them out on their own.	
4. The HMZT does not work as a team, does not meet and does not supervise what is happening in the CCSs.	♦ Organize an emergency meeting with the DDSP to clarify the situation ♦ Retrain the HZMTs to work as a team ♦ Implement monthly HZMT meetings
5. The turnaround between the time a group order is sent and the products are received is too long	♦ Create zonal stocks ♦ Authorize health zones to order directly from CAME while awaiting the departmental warehouse ♦ Accelerate the departmental warehouse implementation process

The DDSP, which participated in this exercise in the Nikki-Kalalé-Péréré zone, expressed its appreciation of this approach and his increased awareness of the importance of systematic problem solving in the following terms:

> "This exercise which PROSAF began is of prime importance. How can we stay informed of these situations if we don't go to the field ourselves? Obviously, everything is connected, it is a system. All the defects in the system come to light regardless of which end of the string is pulled. We came here to solve the drug stock out problem and while assessing the situation, we discovered the HZMT here was not working as a team, there was no supervision, some health centers were being left to their own devices, services were poorly organized and nobody was controlling staff movements, and the COGECs were not doing their job. I am now convinced this type of exercise is essential if the situation is to be improved. All my department heads must get out into the field and see what is happening up close."
> *DDSP B-A at the end of a rapid problem solving session concerning frequent family health product stock outs in a CCS*

Departmental warehouse for essential drugs Implementation of the departmental warehouse has been identified as key to strengthening the logistics system and reducing stock-outs at the health centers. During this year, PROSAF's efforts significantly helped move the process to establish such a warehouse forward at both the departmental and central levels. At the departmental level, consensus was achieved on this warehouse as a structure attached to CAME. The financial and technical feasibility study of the warehouse was conducted with the help of all partners, including the DDSP. A departmental committee (comprising the DDSP partner representative, as well as HZ, COGES and DDSP representatives) was formed to monitor this project. The DDSP identified the site where the warehouse will be built and held negotiations with administrative and municipal authorities. At the central level, the CAME took ownership of the plan and the donors met with PROSAF support to commit to funding the departmental warehouse. The construction company has already been identified and work is scheduled to start in early 2002. PROSAF will contribute furniture to the warehouse and support the adaptation and computerization of the management system.

In addition to the departmental-level warehouse, one of the zones, Banikoara identified the creation of a zonal stock of family health products as a solution to stock-out problems with its CCS and CBSA. Thise zonal warehouse will be integrated with the departmental warehouse. Implementation of Banikoara's solution is supported by PROSAF. If the presence of a zone-level warehouse leads to fewer stock-outs, this experiment could be introduced in other zones in 2002.

3.2.2. Availability of Integrated Family Health Services

During 2001, PROSAF centered its efforts on three activities to increase access to family health services in the health centers:

- Health centers received medico-technical equipment identified as necessary minimum inputs to be able to provide integrated services. For example, the availability of a sphygmomanometer for each nurse will enable him/her to take the blood pressure of a woman requesting contraception instead of referring her to the midwife if she is the only one who has that material.
- Health workers were trained in the Integrated Family Health curriculum (see Results Package 3 for details on this training).

Together, these efforts helped increase the prevalence of integrated family health services as shown in the table below.

TABLE 12 : PROGRESS ACHIEVED IN IMPROVING THE AVAILABILITY OF INTEGRATED FAMILY HEALTH SERVICES

Performance indicator	4th Quarter 2000	1st Quarter 2001	2nd Quarter 2001	3rd Quarter 2001	Observation
Prevalence of Integrated Family Health Service	24% (B-A)		89% (Z)	95% (Z) 57% (B-A)	Measured every 6 months
Fully Vaccinated Rate	37%	-	-	58%	Concentration zones

The objective of 50% that was set for 2001 has been largely exceeded. In the department as a whole, the minimum package of integrated family health services[3] is now being offered five days a week in more than half of all health facilities (57%). The figure is higher (95%) in the PROSAF concentration zones. It is important to note that this indicator does not measure the extent to which a client has actually received the correct set of services, nor does it reflect if the organization of services and patient flow are favorable to integration.

Although the vaccination rate is often considered a measure of individual behavior change, PROSAF sees it as a reflection of access to services. The program's support to the health system and communities has yielded a 57% increase in the proportion of children who are fully vaccinated before their first birthday (from 37% to 58%). This can be partially attributed to the work of the quality assurance teams functioning in four health centers of the Banikoara health zone. Some of the solutions that these teams implemented included an outreach strategy to vaccinate children in villages and increased information on the importance of vaccinations and potential side effects (fear of which is often a disincentive for mothers). In one community in the Banikoara health zone, the community has recruited a community agent who is devoted to outreach vaccination sessions, and immunization coverage has reached 80%.

3.2.3. Community-Based Distribution of Family Health Products

During 2001, PROSAF intensified its efforts to provide community-based health services and extended them beyond its concentration zones to the rest of the departments, in partnership with ABPF. By the end of the year, the proportion of the population in the concentration zones with access

[3] The minimum package of integrated services includes: prenatal care, postnatal care, well child consultation, vaccination, delivery, STI/AIDS, family planning, and interpersonal communication.

to community-based services and products had reached 30%. The implementation of community-based services, which began in early 2000, was accelerated by distributing kits to CBSAs. The table below illustrates CBS coverage and CBSA performance in terms of home visits in the concentration zones. It should be noted that the mini-KAP questionnaire, upon which these data are based, addresses only home visits made two weeks before the survey, while visits may have been made at other times. Gathering information this way to calculate this indicator may, therefore, underestimate the actual prevalence of home visits.

TABLE 13 : PROGRESS ACHIEVED IN EXTENDING COMMUNITY-BASED SERVICES

Performance indicators	**4th Quarter 2000**	**1st Quarter 2001**	**2nd Quarter 2001**	**3rd Quarter 2001**	**Observation**
Community Based Distribution and Services	11%	21%	23%	30%	Measured annually
Community Based Services Agent Home Visit	11% (KAP)	NA	NA	15% (mini KAP)	Measured quarterly

Though it grew gradually during the year, community-based service coverage remained low until the third quarter because of the delay in supplying the CBS kits. PROSAF was obliged to work with several other partners to obtain funding and in-kind resources to equip the CBSA with their initial stock of drugs, which PROSAF contractually is unable to provide.

Contents of a Complete CBSA Kit

- Wooden case
- Backpack
- IEC material (particularly wooden penis, flip charts on family planning and STIs/AIDS)
- Activity book
- Referral and counter-referral sheets
- Contraceptive products (condoms, spermicide foam and tablets caps, oral contraceptives)
- Essential drugs (Chloroquine, Aspirin, Paracetamol)
- Insecticide-impregnated mosquito netting

PROSAF worked directly with the MOH and ABPF to successfully design, plan and facilitate training of the CBSAs. 225 additional CBSAs in the PROSAF concentration and non-concentration zones were trained in the principles of community-based services, malaria, family planning, management and facilitation. These courses were given at the community level (villages, communes) and taught entirely by health workers (direct CBSA supervisors) assisted by ABPF Zone Animators and PROSAF Community Facilitators. A Health Zone/ABPF/PROSAF technical team supervised the training. As is the case with community activities, these courses were taught exclusively in the local languages (Bariba, Dendi and Peulh) so participants could interact effectively and play an active role in the courses. Teaching in local languages also increases accessibility of services in that these CBSA have been trained to discuss concepts in terms that are familiar to the clients, thus reducing linguistic/cultural barriers to access. This training raised the total number of CBSAs to 350, 223 of them in the two PROSAF concentration zones (102 in Banikoara and 123 in Bembèrèkè/Sinendé) and 10% women. Not all CBSAs trained received the complete kit, but they worked with IEC material instead. To prepare for the upcoming community IMCI implementation, the PMA/Nutrition was adapted to the CBSA level and integrated into their training curriculum with the participation of the DDSP, HZMTs and BASICS.

Table 14 below provides and overview of the services and products provided in the community over the course of the year. It should be noted that while the CBSA in all zones were trained to provide counseling services, only those in Banikoara were equipped to provide all of the products listed (and to accompany their counseling). These services and products will be extended to more CBSA in 2002 thanks to an agreement with PAMR to fund the purchase of family health products for Sinendé.

TABLE 14: COMMUNITY-BASED SERVICES AND PRODUCTS				
	Banikoara	**Bembèrèkè/ Sinendé**	**Non-concentration zones**	**Total**
Coverage				
Number of CBSA	102	120	137	359
Number of communes served by CBSA	7	9	11	27
Population served	97,679	96,045	116,450 (approximate)	310,174
CBS coverage (population/CBSA)	958/CBSA	800/CBSA	850/CBSA	
Services provided				
Home visits	376	416	1,289	2,081
Group discussions	540	219	929	1,688
Counseling sessions	635	na	123	758
Products distributed				
Condoms	5,389	na	11,636	17,025
Impregnated mosquito nets	35	na	na	35
Antimalarial tablets	37,620	na	na	37,620
Paracetamol tablets	36,714	na	na	36,714
Aspirin tablets	32,280	na	na	32,280

3.3 Results Package 3: Increased Capacity Of Health Workers To Provide Quality Services

PROSAF Results Package *3: Increased Capacity of Health Workers to Provide Quality Services* supports USAID Benin's IR 3 *Improved Quality of Management and Services.* Major activities include: assessment and improvement of training and supervision systems (including IMCI and QA), integration and improved organization of services using a quality assurance approach, development of monitoring and reporting systems, and strengthening the ties of health workers to the local communities in which they work.

This year's key activities to increase health worker capacity included training in contraceptive technology, infection prevention and in the use of family health protocols, forming quality assurance teams in health centers, and training health zone management teams in formative supervision techniques. Another important achievement has been the introduction of an expanded approach to improve performance of health workers. This approach combines class-training with on the job mentoring and follow-up and subsequent facilitative supervision.

Primary Accomplishments

- Development of IMCI implementation plan (2001-2002)
- Initiation of emergency obstetrical and neonatal care protocols
- Training of health workers in 23 CCSs to use FHS protocols and ten mentors to supervise these health workers
- Formation of departmental training team and development of training plan
- Training of 22 health workers in contraceptive technology in two health zones
- Training of nine mentors and 22 health workers in infection prevention in Banikoara health zone
- Formation, training and monitoring of 21 rapid problem solving teams, composed of members of CCS and communnities
- Training of all HZMTs in formative supervision techniques

3.3.1. IMCI Strategy

This year, PROSAF played an important role in facilitating the introduction of the integrated management of childhood illness (IMCI) into the Borgou and Alibori. PROSAF has been preparing for IMCI since early in the project, using an incremental approach to laying the foundations for both community and clinical IMCI. This follows the successful strategy used for IMCI introduction in Madagascar, where the technical contents or elements of "proto-IMCI" were taught to clinical and community workers in a piece by piece fashion, and the introduction of IMCI then focused on how to integrate these elements.

As the Borgou and Alibori are only the second site for IMCI in Benin, PROSAF has worked closely with BASICS to orient department and zone staff on how the IMCI approach can be used as a strategy to integrate and strengthen their systems-oriented interventions at the DDSP, zone and community levels by implementing its three components (strengthening of personnel skills, enhancement of health system functions, strengthening of Community IMCI). Implementation of IMCI in the Borgou/Alibori began in the third quarter 2001 with the following steps:

Orientation and planning workshop The PROSAF team worked with the DDSP and BASICS to organize a planning workshop for the IMCI launch in the two departments. This workshop oriented stakeholders on the overall strategy and components of IMCI, obtained agreement on the choice of pilot IMCI health zones (Parakou/Ndali, Kandi/Gogounou/Segbana, and Tchaourou), achieved consensus on the content of IMCI for the departments, and developed a plan for 2001-2002 for the implementation of IMCI. These subjects are discussed in greater detail below. PROSAF also carried out individual orientation for one pilot zone that had been chosen but did not attend the workshop.

Pilot health zone selection The following criteria had been proposed by the national level for choice of pilot health zones: 1) accessibility for the regional IMCI technical team, 2) availability and commitment of zone teams to plan and manage IMCI activities, 3) accessibility to a training site near health facilities with acceptable patronage for IMCI training needs, 4) availability of required essential drugs, 5) ability to refer serious cases to referral centers, 6) presence of a partner committed to supporting IMCI activities in the health zone. Based on these criteria, PROSAF proposed that the pilot sites be chosen in its two concentration zones so that IMCI could build on the assets these zones have to offer. However, the DDSP preferred that the pilot sites be chosen in the non-concentration zones so they could also benefit from strengthened PROSAF support in addition to the support they receive from other partners. The zones selected are Parakou/Ndali, Kandi/Gogounou/Segbana and Tchaourou.

IMCI implementation plan preparation (2001-2002) was carried out at the above-mentioned consensus-building and planning workshop in September 2001. PROSAF staff helped each pilot zone develop a budgeted action plan for the clinical, systems and community components of IMCI in their zone. PROSAF also helped plan the next steps for implementation of these action plans. These plans include the three components of IMCI:

- *Strengthening of personnel skills:* In addition to the overall training capacity development done under PROSAF, three physicians, including two pediatricians, were trained with PROSAF support in clinical IMCI and facilitation techniques and will serve as clinical instructors for IMCI. PROSAF will support training in 2002 for 218 physicians, nurses and midwives from the health centers of the pilot zones. This training will include 40% practicum time.
- *Enhancement of health system functions*: Strengthening of subsystems supporting IMCI implementation (drug supply management, referral system enhancement, improvement of access to health services, service re-organization, improvementof health information system, enhanced supervision of trained health workers) are all part of the quality systems approach that PROSAF has been using throughout the project. These systems improvements are part of the health zone action plans developed with PROSAF assistance. The results of these actions will be documented in February 2002 to determine how much the systems strengthening will be able to facilitate IMCI implementation.
- *Strengthening of Community IMCI*: Promotion of key practices in families and communities has been integrated into the action plans that PROSAF helped the health zones develop for their implementation of Community IMCI. Each plan centers around five activities: 1) inventory of community structures that will serve as entry points and be responsible for introduction and promotion of key behaviors; 2) identification of priority key behaviors for the pilot zone according to their health problems; 3) training of a multisectoral team made up of the various sub-prefectoral technicians who will be responsible for training and monitoring community agents; 4) working with community structures and 5) monitoring of changes at the household and community level. In addition to developing an action plan and operating strategies at the zone and community levels, PROSAF helped the zones prepare action plans at the community level.

Creation of a technical steering committee to manage IMCI implementation: PROSAF helped the DDSP establish this committee, define its roles and composition, and assisted with its creation and identification/nomination of members. The committee is made up of DDSP department

heads, medical officers from the three pilot zones, an ENIIAB representative, a private-sector representative, a NGO representative, and the other partners. This committee is mandated to:

- develop the implementation program for IMCI in the Borgou/Alibori
- ensure ongoing development of skills of health workers and various IMCI players via training, formative supervision, retraining and documentation
- monitor, supervise and evaluate implementation in the Borgou/Alibori
- gather all information and data on the IMCI using appropriate tools, as well as process and exploit the data
- oversee product and material management and availability at all levels
- prepare status reports
- report regularly to the health steering committee
- create a partnership with various facilities at various levels

PROSAF helped establish the agenda for the first meeting of the steering committee and facilitate the meeting.

Introduction into CBSA curriculum of 16 key family, community and PMA/Nutrition behaviors as identified by the national IMCI committee was carried out. The PROSAF CSBA curriculum, which has been adopted as the current national CSBA curriculum, will be the basis of the community IMCI curriculum, once the integration of these key behaviors into the existing curriculum has been tested. Information on how to integrate these actions at the community level was collated to guide future community IMCI activities.

Actual implementation of IMCI is slated for first quarter 2002 with the training of clinical trainers, facilitators and then health workers. Monitoring and supervising the health workers, scheduled for second quarter 2002, will make it possible to document the proportion of client-provider interactions observed in which health workers complied with fundamental IMCI standards. Community IMCI will be rolled out as the national committee, PROSAF and other partners agree on the best mechanisms and approaches.

3.3.2. Expanding the Role of Midwives, Including Emergency Post-Partum and Neonatal Care

To extend the role of midwives, PROSAF activities this year were aimed at improving emergency obstetrical and neonatal care (SONU) in the concentration zones in cooperation with the PRIME project. This involved the following steps:

- Training of the departmental SONU committee to provide coaching regarding compliance with prenatal care, family planning, service integration and SONU standards.
- General planning of SONU interventions in the Banikoara and Bembèrèkè/Sinendé health zones in cooperation with PRIME
- Familiarization of health workers in these zones with the minimum package of family health services, taking into account certain aspects of SONU
- Training of seven trainers by the central level to use the SONU curriculum developed by PRIME in collaboration with PROSAF
- Planning of SONU courses for midwives and nurses responsible for birth centers in the concentration zones

The DDSP in collaboration with PROSAF decided to implement SONU in the health centers and zone hospitals. The community level in the concentration zones was not affected this year because the CBSAs have not been trained in SONU, as this was not part of their initial training. However,

PROSAF assisted PRIME with its trial of community SONU in the Malanville-Karimama health zone. The results of this trial will serve as a basis for PROSAF to develop community SONU with the concentration zone health teams.

3.3.3. Family Health Norms, Standards and Protocols

Training health workers and mentors in the family health service protocols is essential to making health workers better able to manage and deliver quality services. The introduction of FHS protocols completes the introduction of the norms and standards done with PROSAF support in 2000. Health workers now have all the skills and tools they need to manage and deliver quality services in the concentration zones. Training of the health workers and mentors to use the protocols follows the integrated training curriculum that includes the minimum FHS package, maternal health, interpersonal communication and quality assurance, the use of data.

PROSAF worked with the DDSP and HZMTs to develop training capacities and a systematic approach to training health workers and mentors in the introduction of the family health protocols, as seen in the following steps:

- Identification of training needs related to the new protocols
- Adaptation of training materials
- Training of mentors/trainers in FHS protocols and mastery of adult-learning training approach
- Training of health workers in 23 health centers in the three health zones of Banikoara, Bembèrèkè/Sinendé and Malanville/Karimama

Training Approaches

Traditional training, or training using the "mastery learning" approach. An effective approach, designed and developed around adult education principles, learning is participatory, relevant and practical. This approach focuses on behavior modeling, is skill-oriented and uses adult-learning techniques?

Mentoring takes place in the work place. Health workers apply skills learned under real conditions in the presence of a mentor who belongs to the facility's health team.

Self-instruction also takes place in the work place. Health workers are responsible for their own learning in the mentor's absence. The self-instruction program is first set up with the mentor. The mentor evaluates performance at the end of the learning and makes recommendations for improvements, which are sent to supervisors for monitoring purposes.

Formative supervision, during which the supervisor helps the health worker improve his/her performance based on the mentor's recommendations.

The methodology followed in this process combined several approaches to ensure that the skills the health workers learned could be replicated in the field in applying the family health protocols. This involved three training approaches (traditional training, mentoring and self-instruction) as well as formative supervision. The various approaches are described in the sidebar. PROSAF has been commended for its use of the on-site mentoring approach that features the informal training of personnel (one or several at a time, depending upon need) by a mentor based at the site for a specified period of time. The mentor integrates him/herself into the team for the purpose of providing tutoring and support to staff to improve their competencies within their work site. Mentors also provide follow-up on provider training by integrating themselves into a health center team and by planning and implementing corrective action plans in collaboration with those team members.

Following the training of health workers and mentors, supervision has shown that 80% of trained health workers are using the FHS protocols and offering the Minimum Package five days out of seven in the concentration zones and Malanville/Karimama zone. Moreover, skill application plans developed by each health worker during training have been implemented by 80% of the health workers trained.

The training of health workers in family health protocols and mentoring has been supported and followed by the MOH. The letter below addressed to health workers by the Minister of Public Health illustrates the interest this approach has stimulated at the central level.

> *Dear Sir and Madam:*
>
> *I would like to commend you on the efforts you have made to improve service quality which you began on September 24, 2001. Development of the Family Health Services Protocols, initiated in May 1999, is currently in the testing phase thanks to you. The approach used to conduct this test is the "Mentoring Based Training" of health workers. This training strategy will enable you to, among other things, learn the skills you need to create pleasant working conditions as well as improve the way you receive patients and organize and integrate services in your health facilities.*
>
> *I cannot put a price on the success of this mission. I know you are highly motivated and are sparing no effort to achieve the training objectives, and I am waiting to assess the results and measure the performance of all of you at the end of the activity.*
>
> *I hope to be able to declare each of your health facilities a "Benin Model Health Center". Please accept my heartfelt congratulations and always remember to listen to your trainers.*
>
> Minister of Health, to express her satisfaction with the new training model

3.3.4. Training Plan and Departmental Training Team

To improve departmental training capacities, PROSAF helped the DDSP put together an annual training plan and departmental training team. All courses given this year were prepared by members of the departmental training team in compliance with the plan and under the supervision of PROSAF and MOH trainers. By doing this, PROSAF has ensured that the departmental trainers have fully mastered the training and supervision methods and can apply them to different topics in various situations.

The process of certifying the departmental training team was carried out throughout 2001. To be certified, departmental trainers are required to properly exercise their training skills in at least two training sessions. Departmental trainers were certified during the series of sessions to train health workers in contraceptive technology, infection prevention and mentoring. Currently, 47% (8/17) of departmental training team members have been certified as trainers and have mastered all the techniques. The box at right describes an experience a mentor had during the mentor introduction and formative supervision process.

> "The lead midwife was really reluctant at the beginning of mentoring based training. She refused to accept the role I had on the team. She thought I was going to replace her. After some time, having seen how we cared for the sick people who came for treatment, how we disposed of needles and syringes and other soiled objects, she cried: 'What beautiful work!' She then called me to ask that I make myself available all the time to help the other colleagues improve their skills.'
> *A mentor in the Bembèrèkè Evangelical Hospital*

3.3.5. Increasing Knowledge of Health Workers

Health worker capacity was strengthened through training in specific topics tailored to needs either expressed or identified through assessment. PROSAF and the Departmental Training Team trained approximately 100 health workers and mentors during the first quarter of 2001 in contraceptive technology, infection prevention, the use of FH protocols and supervision techniques. Supervision, which started in the third quarter, revealed many changes among trained health workers. Compliance with standards of infection prevention such as washing hands before and after each procedure, wearing a lab coat at all times, and preparing decontamination solution was close to 100% of cases.

During supervisory visits this year, it was not possible to observe any health workers involved in a family planning consultation to assess their performance in this area. Demand for family planning services is still low, and women asking for it only go to clinics at night as a discretionary measure. However, the five health workers observed during prenatal consultations followed all PNC standards. These performances were calculated based on scores for fundamental PNC activities.

> "When we go for a prenatal consultation now, we no longer have to wait hours and we're made to feel welcome."
> *Woman, 24 years old, Village of Guéssou-Sud*

Training in different protocols and technologies is one part of PROSAF's strategy to improve knowledge. A second major strategy is to help health workers use quality assurance (QA) methods to continuously analyze their own performance and improve it. Health workers were trained in team-based rapid problem solving (TRPS). As a first major step to institutionalize QA competency among health workers, it was decided to apply the problem solving approach to their work with the communities. By the end of September 2001, 21 QA teams composed of health workers and COGEC members from the two concentration zones had been trained in TRPS. Every QA team has at least two trained members: one health worker and one COGEC/COGES member. The teams in the Bembèrèkè/Sinendé health zone are working to address the problem of poor coverage of prenatal care, and the Banikoara teams are addressing the problem of low vaccination rates. Observations of client-provider interactions and patient surveys conducted during the monitoring of TRPS teams showed that patient reception has improved and waiting lines have disappeared in Bembèrèkè/Sinendé. Also, outreach strategies for vaccination campaigns have been planned and executed in cooperation with communities in Banikoara.

> "Quality Assurance is really a good thing; solving problem of prenatal care alone led us to the problems of poor patient reception, long waiting times, organization of PNC services and the quality of PNC management."
> *Health worker, Bembèrèkè QA team*

Despite these encouraging results from the TRPS teams, it was observed that the teams need considerably more coaching to teach the importance of data to measure the identified problem before and after new solutions are introduced. The challenge in 2002 will be to get the TRPS teams to use routine data systematically in decision-making and to document the results. For further discussion of the problem solving team, see RP5.

3.3.6. Formative Supervision Plan

Implementation of this plan began in earnest in 2001 with three training sessions on formative supervision techniques that helped build the skills of half the members of each of the HZMTs in the Borgou/Alibori (59 people in all). This training was based on a supervision training manual developed jointly by PROSAF, the DDSP and the other partners to give the department the crucial tool it needed to implement the formative supervision plan better, as well as to satisfy a need at the central level

(CADZS) for a reference document it could use to better organize and harmonize supervision in the health zones. PROSAF revised and finalized the manual following this series of training sessions.

Most participants found the formative supervision techniques they were taught to be innovative and totally different from anything they were used to. Furthermore, monitoring of the HZMTs after the training revealed that five HZMTs out of seven (71%) taught other health workers the supervision technique, updated their information system, identified supervision needs based on routine data, and planned and carried out supervisions.

> "In the more than 20 years I've been working, I've attended numerous training sessions in supervision techniques but this is the only time I really understood supervision."
> *Participant in formative supervision training*

TABLE 15: PROGRESS ACHIEVED IN THE SUPERVISION SYSTEM

Performance indicator	4th Quarter 2000	1st Quarter 2001	2nd Quarter 2001	3rd Quarter 01	Observation
Supervision system performance index	9%	38%	10%	46%	Measured quarterly

Training of all HZMTs in formative supervision techniques began in 2001 and produced significant improvement in the performance of the supervision system. Forty-six percent of CCS benefited from at least one supervision visit during the third quarter. Performance was lower during the second quarter due to the involvement of almost all of the HZMT in formative supervision training, resulting in implementation of fewer supervision visits. In 2002 PROSAF will be able to see whether this performance can be sustained throughout the year (four supervision visits per year).

3.3.7. Reporting System to Monitor Training and Performance of Health Workers

The quarterly monitoring guide was finalized and systematically used at the end of each quarter to gather data on the performance of the supervision system. Given the fact that, the supervision system has only recently been implemented, the process for gathering performance data has yet to be systematized. All elements of the system exist but have yet to be integrated, so a program has been developed to exploit data on training, supervision and quarterly monitoring in an integrated way so accurate reporting is available.

However, the training monitoring database was not used optimally to plan and evaluate training. The training team was called on so much to give and monitor training in the field that it was physically unable to update the database. The Departmental Training Team now better understands the importance of good quality, timely date on training, supervision and performance and is committed to better managing and using this monitoring system.

TABLE 16: PROGRESS ACHIEVED IN HEALTH WORKER PERFORMANCE

Performance indicator	4th Quarter 2000	1st Quarter 2001	2nd Quarter 2001	3rd Quarter 2001	Observation
Health worker performance index in prenatal care	-	-	-	100	
Health team performance index in quality assurance	-	-	Banikoara: 40 Sin/Bemb: 64	Banikoara: 100 Sin/Bemb: 100	

3.4. Results Package 4: Increased Knowledge and Behaviors Supporting Use of FP/MCH/STD/HIV Services, Products and Prevention Measures

Results Package 4 supports USAID's Intermediate Result 4: *Increased Demand for and Practices Supporting Use of Family Health Services and Products and HIV/AIDS Prevention Measures.*

During 2001, implementation of the multimedia BCC strategic plan was initiated, and other activities continued with increased collaboration with the Departmental IEC Committee and the Ministry of Health. The BCC plan was developed around a multimedia approach focusing on radio, popular and traditional media, interpersonal communication and printed materials. The strategy document also includes training, supervision, intersectoral collaboration and coordination. The strategy is based on results from various surveys conducted in the Borgou/Alibori, local cultural realities, the role of the Departmental IEC Committee, and the use of local communication channels.

Primary Accomplishments

- Adoption and implementation of BCC strategic plan
- Qualitative study of behaviors related to the low level of prenatal consultation, child vaccination and the use of contraceptives
- Development of 27 counseling cards, four brochures, and two posters as educational material for malaria prevention
- Training of 50 radio and health staff in the Borgou/Alibori on the "Role of radio in health promotion" and techniques for development and production of effective spots
- Assessment of activities and development of a program to broadcast family health messages over the radio in the Borgou/Alibori
- Dissemination of messages on family planning and ways to control childhood illnesses via popular and traditional media
- Pre-testing of two radio serials in French on family planning

3.4.1. Formative and Qualitative Research to Identify Appropriate Strategies and Messages

The choice of appropriate BCC strategies and messages is based on regular data gathering to better understand the types of knowledge and behaviors households must change or adopt. This year, two major studies were conducted with this regard. One was a qualitative study of attitudes toward vaccination, prenatal consultation and family planning, and the other was a quantitative study of family health knowledge and practices (the Mini-KAP), focused on the concentration zones.

Qualitative research was carried out to identify causes of problems that had been identified by rapid problem solving teams. Nineteen participants representing the DDSP, the Departmental IEC Committee, and local NGOs were trained in qualitative research techniques, and subsequently conducted 48 focus group discussions in Banikoara, Bembèrèkè/Sinendé, and Kandi (16 in each zone) The three health themes selected as priority issues to explore included: 1) reasons for low rates of vaccination and pre-natal consultation; 2) reasons for low use of modern contraceptive methods and family planning services; and 3) recommendations for how to improve client-provider relations and encourage men as decision makers to support the use of birth spacing methods by their wives. The three dominant ethnic groups in the areas constituted the target groups for this study.

Many interesting results were derived from this study. In general, knowledge of the importance of vaccinations, prenatal care, and family planning is high. Obstacles to using services include financial reasons, fear of side effects, and lack of support by men. At almost all levels poor reception in health centers was cited as a major obstacle to care seeking and client satisfaction. The results of the study will be used by all of the parties involved in health care, in particular by the rapid problem solving teams. A summary of the study and its main results is presented in Annex 5.

> "As soon as I recognized a CBSA by his backpack, I motioned to him to come and sell me something for my headache. But as soon as I got him in my room, I told him to sell me pills." [laugh from the audience] *(30-year-old man from Banikoara while gathering data for the qualitative study)*

The Mini-KAP measured in the two PROSAF concentration zones and in a non-concentration or "control" sub-prefecture (Ndali) 10 indicators of family health knowledge, attitudes and practices in households. The table below presents the findings of both the KAP/2000, considered as references, and those of Mini-KAP/2001. The explanations provided concern only the Mini-KAP results, which are presented as the average of the four sub-prefectures. In the text, comparisons are made between the concentration zones and the control sub-prefecture when these are significant. Noticeable trends, possible effects of the BCC and community mobilization interventions supported by PROSAF, as well as the impact of these findings on the new directions for the coming year are highlighted.

TABLE 17: TRENDS IN KNOWLEDGE AND BEHAVIORS SUPPORTING USE OF FP/MCH/STD/HIV SERVICES, PRODUCTS AND PREVENTION MEASURES

Performance Indicators	**KAP 2000**	**Mini-KAP 2001**	**OBSERVATION**
Contraceptive prevalence rate	9%	22%	In the PROSAF concentration zones, the prevalence is higher (22% to 25%) than in the control zone (17%). This may be due to PROSAF activities in the concentration zones, such as broadcast of messages via traditional and popular media, and presence of CBSAs. The overall increase in CPR in non-concentration zones can also be attributed to increased clinical training, radio promotion, and ABPF's intensified work in these areas. PROSAF will intensify their activities in the concentration zones and expand them to the other zones, especially with traditional and popular media and Norplant promotion. It will also be necessary to work on supply, since reserve stocks and outside supply channels may be buffering the shortages and lack of capacity shown in the stable CYP measure below.
Couple-years of protection	15089	17237	The couple-years of protection are progressing very slowly due to difficulties encountered in maintaining continued supply and distribution of contraceptives. This problem could be resolved if the departmental family health product warehouse includes contraceptives. Public health facilities (which also count the contraceptives distributed by CBSAs) contributed up to 61% of the total CYP 2001 (APBF 39%). Norplant contributed almost 10% of the total CYP 2001 and seems to be a promising method for boosting CYP in the Borgou/Alibori.
Exclusive breast-feeding	52% (Jan 2001)	ND	This indicator was not included in the Mini-KAP survey because of the large size of the sample needed, as well as the recent data on this (from January 2001)

TABLE 17: TRENDS IN KNOWLEDGE AND BEHAVIORS SUPPORTING USE OF FP/MCH/STD/HIV SERVICES, PRODUCTS AND PREVENTION MEASURES

Performance Indicators	**KAP 2000**	**Mini-KAP 2001**	**OBSERVATION**
Oral rehydration therapy use	15%	50%	There is no noticeable difference between the control and intervention zones. Most PROSAF interventions in this topic – such as radio spots - were carried out throughout the Department. In 2002, ORT is part of the CBS package to be introduced in the concentration zones.
Home treatment/care seeking for fever (Malaria)	49%	64%	The situation is better in Banikoara (79%) than the control zone (66%) and Bembèrèkè (57%) Sinendé (60%), even though relevant messages were broadcast on local radio stations. The higher figure for Banikoara may be explained by the earlier establishment of CBS and better supervision. Launching of the newly developed malaria home management print materials by CBSAs and clinical workers should greatly increase correct home behaviors. These results, although positive, show that synergy among interventions is needed (e.g. using radio messages, counseling and home-based materials).
Knowledge of modern methods of family planning	6%	28%	The level is higher in the concentration zones (22% to 38%) than the control zone (22%). Increased popular media, radio messages, CBSs and education sessions in health centers contributed to these very positive results.
Knowledge of when to seek care for ARI	66%	91%	There is no noticeable difference between the concentration and control zones, with rates varying between 88% and 93% even though PROSAF is only promoting occasional radio spots for the moment. These high rates indicate that PROSAF should now focus on helping households put this knowledge into practice.
Knowledge of child diarrhea prevention	69%	48%	Other than Banikoara, where the level of knowledge is high (59%, again probably due to the longer and more intense activities of the CBSAs) there is no noticeable difference between the control and intervention zones. In 2002, diarrhea prevention will be part of the CBS package to be introduced.
Knowledge of STI symptoms	F: 6% H: 23%	F: 38% H:51%	This significant increase, particularly in Banikoara (50% for women) and Sinendé can be explained by the existence of CBS, traditional media activities and radio messages on STIs.
Knowledge of methods to reduce risk of HIV infection	60%	64%	There is no major difference between the PROSAF intervention zones and the control zone due to the many information campaigns conducted by all partners throughout the region. Despite these high levels, PROSAF must intensify its HIV/AIDS prevention activities to achieve higher knowledge and practice.

TABLE 17: TRENDS IN KNOWLEDGE AND BEHAVIORS SUPPORTING USE OF FP/MCH/STD/HIV SERVICES, PRODUCTS AND PREVENTION MEASURES			
Performance Indicators	**KAP 2000**	**Mini-KAP 2001**	**OBSERVATION**
Knowledge of malaria prevention	55%	29%	In the PROSAF concentration zones, the level of knowledge of malaria prevention using mosquito netting is low (despite radio messages and CBSs) but higher than in the control zone. It is difficult to explain the apparent drop in knowledge of prevention, but in 2002 PROSAF will intensify the promotion and distribution of impregnated mosquito nets through use of the new malaria prevention counseling cards and brochures, as well as CBSA, radio and traditional media activities.
Access to health messages	F: 45% H:62 %	F: 42% H:55%	There is little significant change, although the rates are higher in Banikoara and Bembèrèkè than in Sinendé and the control zone. This could be due to the presence of community radio stations in Banikoara and Bembèrèkè, which contracted to broadcast messages from the HZMTs and PROSAF.

What is obvious from the above table is that there has been some remarkable progress in certain areas, such as contraceptive prevalence, ORT use, knowledge of family planning methods, knowledge of when to seek care for acute respiratory infections, and knowledge of STI symptoms. The BCC strategy of combining several activities (popular media, radio messages, community-based services and education sessions in health centers supported by formative supervision) appears to be an effective package of behavior change interventions likely to improve individual knowledge about family health services and preventive measures, as well as translation of that knowledge into healthy behaviors.

Areas still requiring vigorous and sustained BCC intervention by PROSAF include:
- use of impregnated mosquito netting as an effective means of malaria prevention
- family planning knowledge and use
- child diarrhea prevention
- STI/HIV/AIDS prevention.

The BCC strategy provides for these needs through the planned launch of a radio soap opera that addresses both knowledge and attitudes towards family planning and STI/HIV/AIDS prevention, and the use of the recently developed package of malaria prevention and treatment print materials that focus on the use of impregnated mosquito nets. CRS and PSI have been developing an intensive radio and community-based diarrhea prevention and management campaign that covers the department, and which PROSAF CBSAs can tie into.

3.4.2. Materials and Messages on Family Health Themes Using Traditional Media/IEC

The BCC strategic plan identified priority themes and communication channels based on research findings, results of previous activities, discussions with partners and suggestions by communities. For malaria prevention and treatment, PROSAF developed four sets of counseling cards, four brochures and two posters for use as job aids by CBSAs, health workers and caretakers. In addition, counseling cards on family planning and STI/AIDS were purchased and distributed to CBSAs, which helped them achieve the remarkable increases in knowledge and use noted in these areas. Implementation of the

BCC strategic plan was also furthered by intensifying activities with radio stations and popular and traditional media (theater groups, folklore groups, village orchestras and *griots*).

Development of printed materials for malaria prevention and treatment Four sets of counseling cards comprising twenty-seven images were designed, along with their texts. These sets were in the form of stories that addressed proper treatment of fever in children, chloroquine prophylaxis in pregnant women, use of insecticide-treated bed nets by pregnant women and children, and the economic advantages and mechanisms for obtaining a bed net. The same themes and images were used in a series of three posters - one for pregnant women, one for their husbands (both on the importance of chloroquine prophylaxis during pregnancy), one for men on contributing money towards the purchase of insecticide-treated mosquito netting, and one for caretakers on proper care of fever in children including dosage charts.

PROSAF brought together stakeholders from all levels for a three-week workshop to develop these materials - from the national malaria control program to community health workers, with the private sector, several ministries and NGOs represented. PROSAF used a participatory process for development of these materials, using state of the art technical production techniques to create materials of extremely high quality both visually and in terms of their communication characteristics. The participatory process which emphasized a) use of data for decision-making and priority-setting; b) use of a client focus, c) systems and process analysis, and d) teamwork allowed the creation of educational materials and job aids that are not only effective and appropriate, but also have good buy-in and ownership.

Based on the desired images selected by the workshop participants, local artists and project staff took digital photos which were printed, the images traced on a light board to produce rapid, clear and accurate individual components of drawings that were scanned into the software. This allowed later manipulation of compositions in the computer by easily taking away, adding or re-using figures to create a large number of related products.

Each counseling card has a series of questions and text including key messages on the back. The images in each of the counseling card sets were used to create attractive brochures with minimal text which correspond to each of the four themes. The three posters present the children's dosage chart, the pregnant woman's presumptive treatment dosage, and finally the "health team" showing the family, ASBCs and the midwife, placing the emphasis on their joint effort and shared responsibilities, echoing the RBM theme promoted during the workshop that "the home is the first hospital."

It is planned that with the available budget PROSAF will be able to print about 1,000 copies of the four sets of counseling cards, 500 or each poster, 5-10,000 copies of the brochures for pregnant women, their husbands, and the economic advantages of bednets, and 100,000-150,000 copies of the children's treatment brochure. This would allow provision of the counseling cards to all of the CBSAs in the Borgou and Alibori, a brochure for about one in four pregnant women and their husbands in the next year in the two departments, an economic advantages brochure for ten per cent of the households, and a child's treatment chart for 50-75% of households.

The materials development process culminated with the presentation of results to senior authorities in the MOH, together with partners in health care development. Africare has committed to funding production of the materials for two departments, and several other development partners have made tentative commitments to contribute to the costs of replicating these materials for other areas of the country. In addition to creating valuable materials for use in the Borgou/Alibori, this major capacity and consensus building activity increased PROSAF's presence and visibility at the central MOH level, as well as strengthened collaboration between USAID partners and other development agents.

Intensification of radio activities PROSAF worked to increase the effective use of radio for health education and promotion in the Borgou/Alibori through training, creation of and support for broadcasts, and better coordination between donors, communities, the MOH and radio stations.

PROSAF brought together the MOH and several partners to create a grid of current and planned radio interventions to ensure coordination of topics and timing. PROSAF also provided support to increase and improve radio messages on such topics as family planning, sexually transmitted illnesses and diarrhea, as well as obtaining and pre-testing two existing radio soap operas. These radio activities are being done in collaboration with the Departmental IEC Committee as well as that of PADS, which also signed the contract with two other radio stations.

PROSAF carried out a series of workshops together with the Departmental IEC Committee to increase health and radio professionals' expertise in use of radio for behavior change, and in production of effective spots. In addition, two planning and coordination meetings were held with the four radio stations with which PROSAF and PADS have contracts to assess activities and develop message broadcast programs. These activities produced the following improvements:

- Coordination of radio broadcast timing and choice of messages with HZMT and QA team priorities (e.g. announcements by HZMTs during cholera outbreaks, or notices of increased service availability in health centers)
- Development of higher quality messages including better use of discussion, role plays, and simple, clear, credible and convincing information and sources
- Increased production values, including better use of equipment
- Development of an activity report template,
- Increased understanding by station and health staff of the need to gather feedback following radio broadcasts and improve messages accordingly.

Nevertheless, the need for work specifically with the Nikki health zone and radio announcers there was stressed, along with the need to continue training radio staff to prepare effective broadcasts.

In all, 11 themes were broadcast in 2001, including: cholera (due to the epidemic in Parakou and surrounding areas during the year), vaccination, prenatal consultation, malaria, food-borne illnesses, availability of integrated health services, and existence and roles of CBSAs. PROSAF plans to evaluate this collaboration with radio stations in early 2002. The radio soap opera chosen through pre-tests will be launched early in 2002. Discussion guides for use by radio staff as well as CBSAs and other community entry points will focus on priority areas as identified through research results and feedback from community and MOH sources.

Use of popular and traditional media (PTM) The PTM assessment conducted in the fourth quarter of 2000 recommended continuing these activities, which had been temporarily interrupted. Restarting dissemination of health messages via popular and traditional media in the two concentration zones meant these media could complete the planned first series of 15 shows for each type of media (theater, *griot* and orchestra) and sub-prefecture. These traditional media presentations were very well received and many communities asked to be included in the next series of shows. After this first round of PTM performances, PROSAF took into account lessons learned during the process as well as the findings of the KAP/2000 questionnaire, the study on household decision making, and the problem solving process being followed in the concentration zones to identify causes of problems and thus key messages to be presented.

PROSAF then worked with the Departmental IEC Committee to train a team of trainers to use popular and traditional media in each of the seven health zones in the Borgou/Alibori for the various family

health components (prenatal consultation, vaccination, STI/AIDS, family planning, nutrition, malaria and diarrhea). Key messages for each subject area were developed according to the problems identified above, and each locality chose their priority subjects according to the quality improvement activities being implemented in their health centers, or other determining factors. This second round of performances will be carried out in 2002.

3.4.3. IEC and Counseling Training

Previous IEC training had focused on the role of counseling to convey information. IEC and counseling, including interpersonal communication and the process of behavior change, are now integrated into training courses for family health workers, including CBSAs. The malaria materials workshop and the training on the role of radio in BCC also helped contribute to a better understanding (by MOH personnel in particular) on the importance of integrated, multi-media BCC approaches that help clients acquire not only the knowledge but also the confidence needed to adopt new behaviors.

These trainings to increase health worker understanding of and skills in behavior change have contributed to the increased levels of knowledge and practice observed in the Mini-KAP. These increased health worker skills, in addition to other quality improvement activities carried out by health center teams, helped improve the quality of client reception in health centers, especially in Banikoara and Bembèrèkè. This has reportedly resulted in an increase in health center utilization. Because of their IEC training, CBSAs were able to carry out IEC activities in their communities even though they did not yet have their full CBS kits.

3.4.4. Organize Local NGOs to Train in Health IEC

Many local NGOs have increased their competencies in IEC/BCC through their participation in the above-mentioned activities, such as the radio training, malaria workshop, PTM activities, etc. PROSAF also provided financial, technical and material assistance for awareness sessions organized by CAEB with World Education in schools, and by the *Association des Sages femmes du Bénin* in large businesses and mechanic, welding and woodworking shops. PROSAF also provided assistance to the ROBS training of community-based service agents in IEC/BCC and service provision.

Finally, PROSAF invited seven local NGOs to play an active role in qualitative study activities from startup through to preparation of the report. These NGOs now have a much better understanding of qualitative research, behavior change and behavioral determinants and are now able to conduct qualitative studies in the Borgou/Alibori and, as a consequence, help QA teams investigate households behaviors in relation to family health services.

3.4.5. IEC Activities in Community-Based Development Programs

As discussed above, numerous NGOs and other ministries have participated in PROSAF's BCC/IEC activities, such as the radio training, the malaria workshop, qualitative research, and IEC training. These skills and experiences acquired enable these partners to be more effective in creating health behavior change during their community-based development activities. An example is that staff from the Ministries of Communication and Literacy has learned content (e.g. about malaria or reproductive health), and methods of facilitating behavior change. The literacy staff plans to use the malaria materials in their literacy classes, since they have been developed in three local languages.

More directly within PROSAF, IEC activities in community-based development programs are being carried out in the field by CBSAs, Community Facilitators and Zone Animators in order to decentralize and integrate services (See Results Package 5). Members of the community health structures such as CVS and COGECs are being trained in IEC, as well as the CBSAs, to ensure that all actors in community development can contribute to increased knowledge and improved behaviors.

3.4.6. Capacity of Health Officials to Develop, Communicate and Measure Impact of IEC Messages

After providing BCC training sessions and activities in 2000 for members of the Departmental IEC Committee and other MOH staff, in 2001 PROSAF provided many more opportunities for these health officials to apply this training and strengthen their capacities through concrete exercises. PROSAF worked to strengthen Departmental IEC Committee and other MOH staff capacity this year through:

- joint development of the BCC 2001 work plan
- continuation of the organization of and evaluation of campaigns for national and international days (Health, Vaccination, AIDS) by Departmental IEC Committee members with PROSAF support
- involvement of Departmental IEC Committee members in the development and finalization of the BCC strategic plan as well as its implementation
- participation in the malaria print materials workshop
- involvement in training and supervision of popular and traditional media activities
- participation in work with local radio stations to improve the quality of BCC broadcasts and to ensure better coordination of radio content with HZMT priorities and needs
- involvement in qualitative studies of PNC, vaccination and family planning

Most of the above-mentioned activities involved bringing the MOH and Departmental IEC Committee staff in on conceptualizing, planning, implementing and evaluating the BCC strategic plan and activities. The malaria materials development workshop, in particular, allowed MOH and NGO staff to review behavior change theory, identify multiple intervention possibilities, analyze priority needs, and create targeted materials. The workshop on use of radio, with internationally-known radio personality Georges Collinet, allowed Departmental IEC Committee staff and other local health and communications specialists to increase their understanding of the various radio “products” and how they are best used and produced.

Through this collaboration with PROSAF, the Departmental IEC Committee has gained greater competence in organizing and managing social mobilization campaigns, which it demonstrated during the World AIDS Day, cholera epidemic and National Vaccination Days by developing plans and budgets, carrying out activities and providing narrative and financial reporting.

3.5 Results Package 5 Increased Community Involvement in Planning and Delivery of Community Level Health Service and Prevention Measures in Selected Target Areas

PROSAF's Results Package 5*: Increased Community Involvement in Planning and Delivery of Community Level Health Service and Prevention Measures in Selected Target Areas* directly relates to and supports achievement of USAID Benin's Intermediate Result 1: *Improved Policy Environment* and Intermediate Result 4*: Increased Demand For and Practices Supporting Use of Family Health Services and Products and HIV/AIDS Prevention Measures.*

This year, PROSAF continued strengthening COGEC/CCS and COGES capacities by helping them expand their roles to developing and implement budgeted plans and negotiating budgets with HZMTs and partners, as well as playing a larger part in managing the quality of health care services. It also helped create and start up village health committees, which are responsible for resupplying CBSAs, attending community meetings organized by CBSAs and COGECs, and helping mobilize communities during visits from the problem solving team.

Primary Accomplishments

- Active Involvement of COGECs and Village Health Committees (CVSs) in team-based rapid problem solving process at CCS level
- Training of CVS and Local Volunteer Committee (CLV) members in their roles and responsibilities, and conduct of effective meetings
- Training of COGEC and COGES members in their roles and responsibilities and in how to conduct effective meetings
- Midpoint review of 2001 COGEC action plans and budgets jointly carried out by CCS and COGEC

3.5.1. Identification of Concentration Areas

At the beginning of the PROSAF program three sub-prefectures were identified as the concentration areas for intensive community level interventions. The selection of these sub-prefectures was based on criteria such as poor health service utilization indicators, absence of other major health sector partners, and presence of other USAID partners to test synergy potential. The three sub-prefectures selected - Banikaora, Bembèrèkè and Sinendé - have since been regrouped into two health zones under the MOH decentralization reforms (Banikaora and Sinendé/Bembèrèkè).

The activities to meet this output have been completed.

3.5.2. Integration of PROSAF Results Packages with Selected Health Centers and Communities

The activities for the achievement of this result were actually embodied in the team-based rapid problem solving process in the 21 CCSs of the concentration zones, as described in Results Package 3. Teams were formed and included client representatives, COGEC members and health workers. The team was given the responsibility to analyze and solve priority health problems. The creation of these teams has been very important. It has actually been the first time that health workers and communities actively work together to improve the health status of the communities. All aspects of health service delivery and utilization are part of the analysis, and development of solutions. Major steps in problem

solving include the identification of a problem, analysis of root caused to the problem, development and implementation of solutions and monitoring to verify that the solutions that are being implemented have the desired effect.

In Banikoara, 10 problem solving teams including community members have been working to identify reasons for low rates of child immunization, and identifying ways to increase them. Their first step was to conduct a qualitative analysis of how households use family health services. In Bèmbèrèkè/Sinendé, the 11 teams formed have been working on poor prenatal care coverage. They also used the community-based qualitative analysis to identify reasons for the low coverage.

> "The one thing that really impressed me this year is that now a woman can go for a prenatal consultation at the health center and come back in time to go work in the fields. The health workers look after us very quickly."
> *Female member of CVS, Beroubouay CCS*

TABLE 18: EXAMPLE OF PROBLEMS IDENTIFIED AND SOLUTIONS DEVELOPED FOR SEVERAL PROBLEM SOLVING TEAMS

Health Center	Causes Identified	Components of Solutions
Guessou-Sud	♦ Perceived discrimination on the part of certain ethnic groups ♦ Linguistic barriers: Health workers do not speak local languages ♦ Long waiting times for prenatal consultations ♦ Lack of vaccines and basic drugs ♦ Large distance between some villages and health center ♦ Lack of knowledge on importance of prenatal care ♦ Forgetting of dates of prenatal services ♦ Modesty and lack of trust to be examined ♦ Shame to show pregnancy (primipares)	♦ Inform clients on schedule of service based upon order of arrival ♦ Share information about availability of prenatal services every day ♦ Reorganize prenatal services so that they are offered as soon as women arrive ♦ Ensure that there are no stock-outs ♦ Raise awareness on the importance of prenatal care in villages ♦ Set up a system to involve Community health workers to remind women of appointments and to identify pregnant women
Fôbouré	♦ Poor reception of women (yelling) ♦ Too much IEC before services ♦ Services only offered twice a week ♦ Health workers lack information about prenatal care ♦ Women do not know about importance of prenatal care ♦ Some villages are far away ♦ Women forget dates for return visit ♦ Shame	♦ Train health workers on new integrated service model, on importance of good reception, respect of hours ♦ Raise awareness with the population on importance of prenatal care, and that services are now available every day ♦ Counsel women individually on importance of prenatal care ♦ Strengthen financial basis of women by organizing *tontine*
Sèkèrè	♦ Long waiting times ♦ Women forget return visit dates ♦ Shame and refusal to undress ♦ Lack of understanding of importance of prenatal care ♦ Worry about side effects of folic acid	♦ Provide counseling to women at every opportunity ♦ Mark date for return visit clearly on *carnet* and suggest women seek help in village to remind them ♦ Outreach program to raise awareness on prenatal care, information about side effects
Sinendé	♦ Long distance to some villages ♦ Lack of information about importance of prenatal care	♦ Raise awareness of villagers on importance of prenatal care ♦ Carry out outreach strategy

The solutions developed were elaborated in the form of micro-plans. As can be seen from the table, the solutions draw on activities from the different technical areas that PROSAF supports. While it was not intended this way, the solutions that the combined health center communities have developed, significantly contribute to a better implementation of integration.

The problem solving teams are being coached by Community Facilitators and HZMT members. They are supposed to meet once or twice a month to review and update their work plans. This a large commitment of time and energy. In Bèmbèrèkè, all teams succeed in meeting their own goal. In Banikoara this was not the case, especially in September. This is due to the intensive farming that takes place in September, making it hard for community members to participate. The experience to date with these teams despite observed deficiencies, has been very positive. The actual experience of working together on commonly identified problems, the process to learn to collect, analyze and use data, and the work sessions themselves all increased the level of trust and comfort with each other. Instilling this culture of quality is a process that takes time and ongoing support. PROSAF has planned a combined and intensified support to these teams, as well as more work with the Health Zone Management Teams to better equip them to guide and supervise the CCS, community teams. A good example of the underlying commitment of the teams was recently demonstrated in Bankoara. Clarification of funding options for some of the solutions has accelerated the implementation and renewed team member commitment. Results will be documented as they become available.

3.5.3. Capacity Building of COGES and COGEC

Quarterly monitoring of COGEC/COGES performance allows PROSAF to track the extent to which its capacity building efforts are producing results. The COGEC Performance Index measures the planning and management functions of the COGEC and is based on six criteria covering planning, implementation of activities, financial management, community awareness-building, inventory management and regular meetings. The Index remains high at 85% in the third quarter.

TABLE 19: PROGRESS ACHIEVED BY THE COGEC/COGES AND CVS

Performance indicators	**4th Quarter 2000**	**1st Quarter 2001**	**2nd Quarter 2001**	**3rd Quarter 2001**
Performance Index for COGEC	70%	74%	86%	85%
Performance Index for CVS	ND	ND	ND	39%

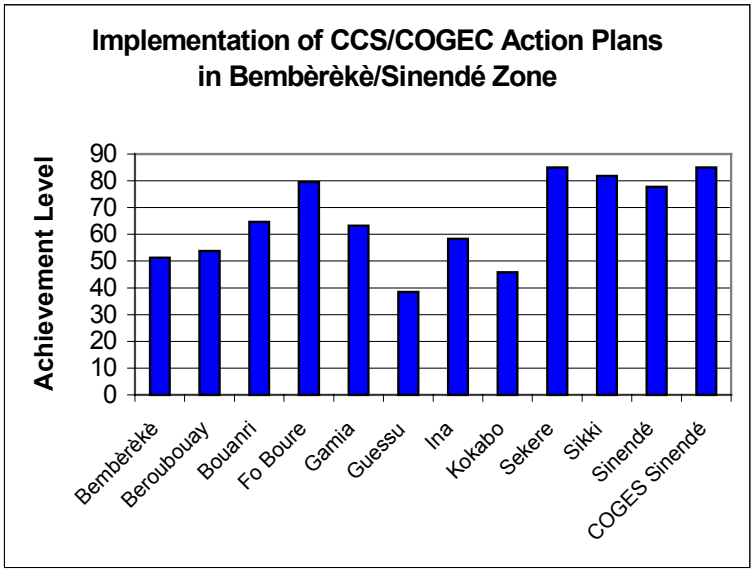
The performance of village health committees (CVS) in the concentration zones is measured using the CVS Performance Index. This is based on the number of meetings held, implementation of planned activities, and action taken on problems raised by the CBSA. The CVS Performance Index could only be calculated in the third quarter of 2001 because of the delay in setting up community-based services, which are managed by the village health committees. CVSs are currently only active in the Banikoara health zone where CBSs are fully functional (Performance Index 53%). In Bèmbèrèkè/Sinendé activities have just started, resulting in a Performance Index of 26%. The overall achievement level for the two zones is 39%.

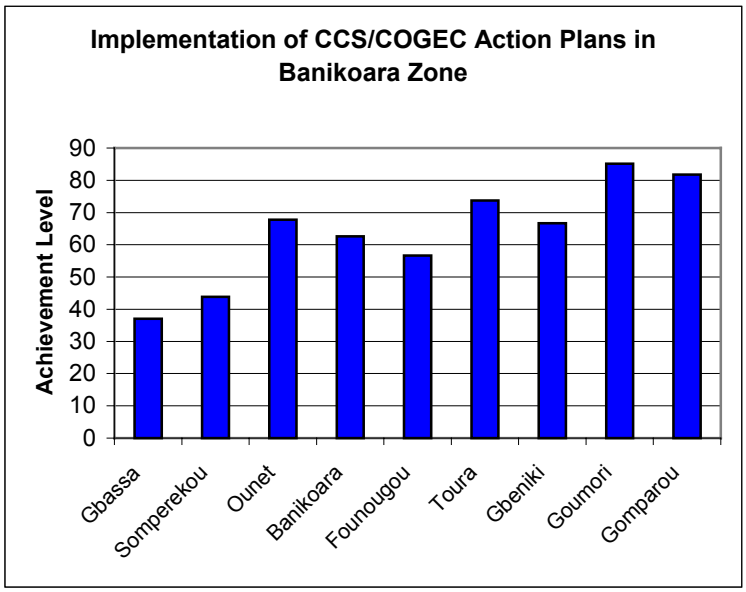
"We health workers are best placed to say how the way we work has changed. In the past , we received a letter that asked us to send a budget within a very tight deadline. We dug through the paperwork and if we found the one from the year before, we adjusted it a bit. Otherwise, we went next door to find one. We never knew our achievement level. In addition, PROSAF gave us a chance to show the community how we work. We now understand what an organization like the COGEC or a problem solving team can do for a health center."
Health worker in Beroubouay CCS

Nevertheless, this exceeds the 25% target for 2001. The COGECs and CVSs achieved this performance level by carrying out the following activities in cooperation with the various stakeholders:

Community midpoint review of COGEC budgets and action plans In 2001, 21 community workshops were held to conduct a midpoint review of the implementation of action plans and budgets of the 21 COGECs in the concentration zones after six months of implementation. Analysis of the plans showed an average achievement level of 65% (proportion of planned activities actually implemented) as the graphs below illustrate for the two health zones. However, health promotion and education activities had a low achievement level (30%) for reasons the participants themselves analyzed:

- Insufficient coordination between the DDSP and health zones means that the director or signing authority for CCS accounts is frequently absent.
- Funds to finance activities are disbursed slowly.
- There is a reluctance to disburse funds for non-clinical activities.
- COGEC members and health workers have trouble accomplishing their monthly microplanning based on annual action plans.
- The "Plan-Implement-Monitor-Evaluate-Plan" process is not yet well established as a work method with staff at the CCS level.





The many comments recorded indicate the satisfaction felt by health workers and COGEC members alike for their joint work and this detailed implementation analysis. This review and planning exercise was the very first one they had carried out in 13 years of joint management. It is now a matter of ensuring the review exercise is repeated on an ongoing basis until it becomes automatic.

The difficulties observed with regard to financing non-clinical activities confirms the belief that administrative and financial

management procedures will have to be updated through consensus and that new strategies for financing health costs should be tried, including proven income-generating activities. Both of these are planned for next year.

Development of a COGEC/COGES and CVS training program A skill-centered program to train COGEC, COGES and CVS members was developed, along with a curriculum in three local languages (Bariba, Dendi and Peulh). Training sessions were organized in the villages with the full participation of village leaders. Two training sessions on two topics were attended by a total of 395 COGEC/COGES members. 186 COGEC members (including 19 health workers) were trained in their roles and responsibilities for the joint management of health centers. The specific objectives of the training were:

- Explain primary health care principles and implementation strategies
- Present national health care policy objectives and strategies and the various levels in the Benin health pyramid
- Explain the principles of community participation and joint management
- Identify COGEC/COGES/CVS members' tasks
- Define principles of teamwork

> "A little less than two years ago I had no idea the CCSs were operating with funds generated from services by health workers. I thought everything came from the government. Now I am aware of all the sources of CCS funding because I developed and implemented the AP/Budget for our CCS."
> *COGEC member, Sikki Peul 1*

In addition, 209 COGEC/COGES members learned how to conduct effective meetings, write minutes and develop their internal regulations. These courses made COGEC/COGES members aware of the importance of their role and the need to perform it properly. The immediate effect was that regular meetings are being held, as the graph below illustrates.

Strengthening of local NGOs capacity to help set up CVSs Due to the quantity of people needing training, PROSAF decided to draw on the resources of local NGOs in the Borgou/Alibori. Seven NGOs were selected based on their previous work with other USAID-funded programs. Thirty trainers were trained in training methodology using adult education methods. At the end of the training, these participants developed a CVS training curriculum covering the following nine topics: financial management, CBS concept, meetings and minute writing, conflict resolution, roles and responsibilities of the various stakeholders, community mobilization, monitoring and evaluation of CBSA activities, and budget planning. This training and curriculum development was put to use as described below.

Training of CVSs to support CBSs These 30 NGO trainers trained 1,325 members of 280 CVSs/CLVs in cash and bank book management, meeting facilitation, organization of the Benin health system, CBSA tasks, and activity programming. Ninety per cent of CVS members participated, despite the intense agricultural work at that season.

News about the various training sessions given and planning workshops held spread to so many villages that many village groups of farm producers and the Sub-Prefecture Producers Unions asked Community Facilitators for the same type of assistance.

> "At first, I didn't understand much. CCS activities were not going well. Now there's been a very big change. Anyone who says now they don't know what's going on in the CCS is lying. Everyone knows what happens there and there's always room to learn more. People used to avoid the center. Nobody even knew who really managed it."
> *Membre COGEC (Sikouro) Ina*

3.5.4. Financing Sustainable Community Level Interventions

Discussions to implement mechanisms for financing sustainable health care interventions at the community level (credit system for financing income-generating activities) continued this year between the DDSP and USAID. The model that achieved consensus at PROSAF is to develop this activity as a pilot intervention and limit it to COGECs in four or five health facilities at first.

4. CHALLENGES AND OPPORTUNITIES

The PROSAF program has worked closely with the departmental, zone and community levels, as well as with other partners, and has had considerable success during the year 2000. Perhaps the most significant result is the change in attitude of the health workers and communities alike. They acknowledge that change is necessary, that it is feasible to carry out improvements, and that many of those are within their own power to bring about.

There are, however, a number of major challenges that PROSAF has encountered that will need to be acknowledged and addressed in coordinated decision-making between PROSAF, USAID, the MOH, partners and others. These are:

4.1. CHALLENGES

Helping the DDSP and HZMTS to Work as a Team Although this is a change from traditional hierarchical structures, the DDSP and HZMTs recognize the benefits of teamwork and made the first steps towards introducing it into their management approach. The DDSP and HZMTs were familiarized with QA and trained in formative supervision techniques. The DDSP especially benefited from a team building session.

In 2002, PROSAF will continue supporting team building at the DDSP and zone levels. The DDSP will also benefit from an organizational diagnosis to help it better organize its services. PROSAF, working with the DDSP's other partners, will support implementation of administrative and financial management procedures to facilitate teamwork at both levels.

Reconciling PROSAF's Pace of Work (and Achievement of Objectives) With the Pace of Work of the DDSP and HZMTs Since PROSAF is a program based on achieving objectives within a specific period, it must work at a relatively rapid pace. The DDSP and health teams have a hard time maintaining this pace, even though activities are planned together. Moreover, some of the activities carried out over the year were activities that were supposed to be part of health workers' and managers' regular jobs. One especially relevant example is supervision activities, which were supposed to be carried out on a quarterly basis.

PROSAF made an effort to address the real problem of health workers being away from their posts for extended time due to training. This year, training in the use of FH protocols, in mentoring and training of HZMTs in formative supervision required an enormous amount of time from health workers and the DDSP team. As a result, PROSAF developed a new training model to cut down on physical absences from the workplace by introducing mentoring.

The real challenge in 2002 will be to continue motivating health workers and management teams in the departments and zones to take ownership of health program objectives, specifically improving health service use and quality.

Ensuring the Quality of SNIGS Data The quality of SNIGS data compiled by health workers is a major challenge. Health workers gather the data every day without really being interested in their quality and use. During monitoring visits, it has been noted that many forms are being poorly filled out and are thus unusable. These deficiencies extend as far up as the health zones and DDSP. This lack of concern for data quality proves that the culture of regularly using data for planning and decision-making has not yet become a habit.. PROSAF and the other DDSP partners have decided to use the

scoreboards and supervision grids as tools to institutionalize the regular use of routine data for decentralized planning and decision-making.

Accordingly, the QA monitoring team's suggestion to organize a departmental meeting on data use provides an opportunity for the central level and DDSP to commit to and take ownership of this process.

Formalizing the Culture of Quality in the Borgou/Alibori Since most DDSP, health zone and CCS stakeholders have been familiarized with and/or trained in QA, the next step will be to integrate the various QA activities into health workers' functions and responsibilities. Several partners, such as the PBA and PRIME, are convinced of the need to pay particular attention to service quality and have, therefore, become QA advocates to health workers in the Borgou/Alibori. The big challenge will be to help make health workers better able to use QA tools to continually improve services so they are more efficient and better satisfy the needs of the population.

Helping Health Workers Become Multi-Functional In Providing Integrated Services Much progress has been made in introducing integrated services into the health centers. PROSAF targeted the CCSs and private clinics (ABPF and OSV Jordan) as the focal point for offering the minimum package of integrated family health services. The content of this package was defined and health centers were supplied with medical equipment to facilitate integrated services. Health workers, especially those in the two concentration zones, were trained to use family health protocols via an integrated curriculum. At the end of every quarter, every health center in the Borgou/Alibori is monitored to verify that integrated services are actually available and being offered five days out of seven.

Nevertheless, integrating services does not mean simply making them available on a daily basis. It also means integrating them into personnel responsibilities, and making them more efficient by using human resources more effectively. At this stage in the integration process, it has been noted that nurses and midwives (or workers performing those duties) still work separately in the same health center. Nurses are concerned only with curative care and midwives with PNC and childbirth. PROSAF's challenge in 2002 will be to get the DDSP, HZMTs and health workers to understand and agree to the need for all-round integration, then to give health workers cross- training and, finally, to ensure the trained health workers use this integrated approach on the job.

Implementing a Bottom-Up Annual Activity Planning Process PROSAF has put a lot of effort into developing strategic and operational plans and budgets for the various levels of the health pyramid (DDS, HZ, CCS). What is still missing at this point is integration of the various plans. For example, health zone plans are developed without taking into account priorities and strategies proposed by CCSs. The same is true in the DDSP, which lacks a mechanism for analyzing HZMT action plans. The challenge in 2002 will be to help make this planning process more coherent and interdependent at all levels, so that annual plans and budgets at each level always take into account those of the level below, strictly respecting each one's mission. The management plan developed jointly by PROSAF and the DDSP will be disseminated to all levels and used as the basis to support application of the planning cycle.

Maintaining Availability of Family Health Products The problems health zones are having in providing health centers and CBSAs with a steady supply of FH products have negatively affected the implementation of community level activities and the delivery of PMSISF services and, at the same time, created challenges that must be overcome. In the Banikoara health zone for example, the CBS model stipulates that the CVSs be resupplied from the CCSs if needed. The CCSs were unable to meet demand because they did not have a sufficient quantity of these drugs. Following an analysis, the

HZMTs, working with the health center heads and COGECs, created a buffer zonal stock of FH products which has helped decrease stock outs at the village and commune levels. The SEPD at the DDSP/BA level wants to use this initiative as the basis for solving FH product stock out problems in the other health zones. PROSAF will provide special support to the SEPD to implement this strategy during 2002.

Promoting the Self-Financing of Health Promotion Activities An assessment of CCS action plans showed that health promotion activities have an implementation rate of less than 40%, while implementation rates for clinical activities (curative care) are close to 100%. This situation can be explained by the lack of financial resources and a fear of using health center resources for activities considered "non-clinical". PROSAF's challenge here will be to help clarify the objectives for authorized expenses and the financial management procedures. On the other hand, PROSAF has planned activities to help identify permanent sources for financing health costs other than the sale of drugs.

Inciting Health Workers to Supervise CBSAs in the Field PROSAF helped set up in the concentration zones a network of 222 CBSAs who are all functional today. The big question now is what to do so nurses and midwives in the CCS concerned regularly and independently supervise CBSA activities. Having health workers supervise CBSAs will build a bridge between the health centers and these community agents and thus facilitate contact between health centers and communities. Supervision remains the critical success factor of any CBS program since it is a source of ongoing training and motivation for CBSAs who see their work valued/recognized by the health facilities to which they play a complementary role. Supervision by health workers is part of what will ensure the sustainability of their role.

4.2. OPPORTUNITIES

Enlarging the DDSP Team DDSP and health center personnel increased through either new assignments or new recruiting efforts. Two physicians and two administrators were assigned to the DDSP, and a large number of nurses and midwives were recruited to augment health center personnel via the Benin government's "social measure" policy. This influx of additional personnel is a real opportunity to monitor and coach health zones on the one hand, and to strengthen the integration of services in the health centers on the other.

Advocating for the Ongoing Supply of Contraceptives and Family Health Products The national advocacy workshop to ensure contraceptive availability in Benin, organized jointly by DELIVER and the DSF/MOH, is a ray of hope in dealing with constant stock outs in contraceptives and essential drugs. Until these stock outs are brought under control, it will be very difficult to significantly increase the use of family health services. This workshop was attended by the key players and adopted a uniform action plan for the Ministry and donors. Discussions included issues concerning the purchase of contraceptive products, the need to improve collaboration among donors, forecasting techniques, the analysis of funding needs and logistics advocacy. It is hoped that the MOH and its partners will use the Action Plan developed by the workshop and presented to the invited donors to help the Borgou/Alibori overcome this crisis.

Integrating the systems used to supply contraceptive products, vaccines and generic essential drugs remains, despite everything, another major challenge for the coming years.

Obtaining Commitment from Donors to Fund the Departmental Warehouse The commitment to funding the departmental warehouse expressed by donors at the round table concerning that matter

was a major opportunity that PROSAF and CAME used to promote the warehouse to other potential donors. As a result, the Coopération Française, which did not attend the round table, agreed to help fund construction of the warehouse. This was a major boost for the project.

Negotiating Partial Funding from PAMR to Purchase Drugs for Sinendé CBSAs Since PROSAF is not able to purchase the initial stock of drugs and contraceptives for CBSAs, they identified PAMR as a partner who could. Community Facilitators trained the Bèmbèrèkè-Sinendé health zone CVS and helped them to prepare project grant applications and submit them to the PAMR. Partnership agreements were signed between each CVS, PAMR and PROSAF, and part of the PAMR funding (nearly ten million FCFA) was recently transferred to the Sinendé CVS accounts. Drugs and contraceptives were thus ordered and the health zone can now start CBS activities.

Change in the Ministerial Team at the National Level A new Minister of Health was appointed in the second quarter of 2001. The new minister has taken a direct interest in questions of service access and quality. In her speeches, directed at both partners and health workers, she stresses the need to implement strategies that will ensure the delivery of quality services to the population. To demonstrate her commitment, she appointed the former coordinator of the national QA program as the new Director of the Family Health Department. She also appointed a QA advisor to her cabinet.

Furthermore, the increased PROSAF collaboration with central level staff and the restitution, by request, to central MOH authorities of the BCC printed materials development process help give PROSAF's achievements a national scope.

Creation of a Ministerial Committee to Monitor USAID Health Programs A new committee to monitor USAID health programs at the ministerial level was formed this year. PROSAF is the representative of the partners in the field. This committee promises to be a forum in which information will be shared and policy issues can be raised and debated.

5. PROGRAM MANAGEMENT

5.1. Support for DDSP and Health Zones

In the context of strengthening DDSP services and improving the work setting, the program financed the renovation of the DDSP computer room. A company was selected to supply and install a telephone system with a view to strengthening the DDSP's internal and external communication system.

PROSAF concentrated outfitting efforts this year on the health zones. Computer equipment, furniture and small medical appliances were distributed to make health facilities better able to provide integrated services. At the same time, another small-equipment needs assessment was conducted for these health centers. PROSAF replaced the electronic microscope in the Sounon Séro zone hospital following a fire in their laboratory.

5.2. Administrative and Financial Management

PROSAF's administrative and financial system was strengthened in 2001. The key aspects of this activity included:

- a thorough review of the PROSAF accounting financial management database. All data in the system were analyzed so they would comply with the program's budget recommendations;
- implementation of an activity-based budget model;
- examination and improvement of financial management procedures.

PROSAF also finalized and distributed its administrative procedures guide for staff. A set of procedures to use with the partners based upon PROSAF's guide, was distributed.

5.3. Personnel

Important staff changes this year were the change of Coordinator heading the program, in September and the recruitment of a BCC specialist. This specialist will take office in January 2002.

Field and administrative support personnel grew. PROSAF recruited three Community Facilitators this year because of the workload and in anticipation of income-generating activities.

The administrative staff has been enhanced with the hiring, on a temporary basis, of a stock manager to help with reorganizing the inventory system and rigorously applying instruments for stock management. In addition, PROSAF hired an IEC Assistant Coordinator, in order to support the IEC Coordinator on a temporary basis.

5.4. Milestones Accomplished

Five milestones (contractual results) have been achieved and were approved during the year. They include:

- Assessment of supply systems (emphasizing contraceptives, ORS and other family health products, as well as essential drugs) within Borgou completed
- Report on BCC needs produced from an initial assessment and formative/qualitative research
- BCC plan developed based upon the initial assessment

- Traditional channels of communication being used to disseminate family health messages and information
- URC prepares acceptable results report (by December 30, reporting on the previous fiscal year period)

5.5. Field visits and Consultations Managed by PROSAF

PROSAF took advantage of visits from several USAID staff, URC home office and implementing partner technical staff and consultants to provide technical assistance.

One of the highlights during this year was the visit of Mrs. Hope Sukin from USAID/Washington, who came to gain a better understanding of PROSAF activities, to meet the PROSAF partners and to make some recommendations for strengthening planning and coordination among the partners. In this context, a meeting took place with the DDSP, PROSAF and BASICS, providing an assessment review of these two programs and their challenges. Mrs. Sukin emphasized the connections made with national policies and other efforts to share the lessons learned with the other department in order to ensure the sustainability of PROSAF achievements and its appropriation by the Ministry of Health. She praised PROSAF for its work at the community level, for strengthening systems, and ties with the implementation of national policies. Finally, she suggested to PROSAF that it enrich the program by deepening its analysis of certain problems in sensitive services such as immunization. In this way, PROSAF could tackle the real obstacles presented by these subsystems. All of these suggestions and recommendations will be taken into account in the plan for the fourth quarter of 2001 and in PROSAF's 2002 annual plan.

PROSAF also benefited from the visit of the USAID Health Program Monitoring Committee.

6. PROGRESS TABLES

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
Volet I : Amélioration de la Planification et la Coordination			
Résultat 1.1: Développer et mettre en œuvre un plan pour accroître la capacité des agents de santé du Borgou aux niveaux départemental et des zones sanitaires	Elaborer un plan de renforcement des capacités en gestion	Un draft du plan pour le renforcement des capacités de la DDSP et les EEZS en gestion est élaboré et partagé avec la DDSP.	Ce plan sera finalisé et validé au cours du 1er trimestre 2002.
	Mettre en œuvre et suivre le plan de renforcement de la gestion à travers les requêtes ou programmations CODIR.	Atelier d'Orientation du DDS et des Chefs Service de la DDS à l'approche Assurance de Qualité.	Les activités ci-dessous permettent la mise en œuvre de ce plan.
	Trois sessions de formation des agents de santé et des EEZS en AQ et résolution des problèmes dans les zones de concentration et les autre zones.	Quarante agents de santé et membres communautaires formés en résolution rapide des problèmes.	Le problème majeur identifié par le suivi est la difficulté qu'éprouvent le équipes AQ et particulièrement les prestataires à utiliser les données qu' collectent tous les jours pour calculer des indicateurs simples et prendre décisions.
	Atelier pour contribuer à l'élaboration et mise en œuvre des procédures de gestion des ressources humaines afin d'améliorer la motivation et l'engagement des prestataires. (ex. description de poste)	Un module de formation qui sera utilisé au cours de cet atelier est en cours d'être adapté à partir des matériels de référence fournis par le CADZS et le MSP/DRH.	Cette activité a été discutée avec les nouveaux chefs de service administ financier et gestion des ressource humaines. Un consultant assiste le se des ressources humaines à rédiger un module de formation pour les EEZ Deux autres modules seront finis pour les EEZS avant la fin de l'année.
	Revue des outils et organisation/ préparation de l'évaluation de la qualité de la gestion du système sanitaire (EQGSS.)	Les Termes de Référence du Consultant qui sera chargé de cette évaluation est rédigé et le consultant identifié.	
	Deux ateliers et sessions de coaching pour développer les compétences en leadership pour tous les niveaux	Un atelier sur AQ avec les chefs service DDSP focalisé sur les rôles et fonctions de la DDSP a inspiré les réunions de staff hebdomadaire. D'autres recommandations issues de l'atelier sont: le recensement de toutes les normes administratives et de gestion, leur vulgarisation et application dans tous les Services; le suivi et l'appui des services de la DDSP aux activités AQ en cours dans les ZS.	L'atelier prévu pour ce trimestre a été reprogrammé au 4ème trimestre.
	Assistance aux EEZS dans l'élaboration d'un manuel des procédures standardisé de gestion dans les zones sanitaires		Suite à un audit des centres de santé, ce manuel de procédures standardi été suggéré comme une des solutions pour le manque d'harmonie dans la gestion par les nouveaux chefs de service administratif et financier et g des ressources humaines

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
Résultat 1.2: Développer des plans stratégiques et opérationnels en santé familiale en collaboration avec les partenaires publics et privés	Séances de coaching sur site de travail pour le développement des compétences des agents de santé en planification, mise en place et évaluation des activités.	Les agents de 21 CCS ont été coachés en matière de revue à mi parcours de leurs plans d'action budget cf résultat 5.3.	Les séances de coaching constituent une activité transversale prises en c dans tous les volets.
	Deux ateliers de concertation et planification pour impliquer les responsables HZ dans le processus de planification des EEZS	Atelier réalisé à Bembèrèkè et le draft du plan 2002 soumis pour approbation	Une rencontre d'harmonisation avec les partenaires sera organisé au cou 4ème trimestre. Les plans d'action des CCS seront intégrés.
	Identifier les besoins en ressources matériels et assistance technique pour appuyer EEZS en ressources dans la mise en œuvre de leurs PA (pendant les CODIR elargi départemental).	Un inventaire des besoins en équipement est fait et une harmonisation des demandes est en cours avec une liste standard de l'UNICEF.	La commande sera faite basée sur un tri des équipements essentiels et le ressources disponibles.
	Participer aux séances de concertation avec les EEZS	PROSAF a participé aux séances et réunions suivantes : l'installation de l'EEZS et du comité de santé à Tchaourou et à Bembereke / Sinenede, et la réunion trimestrielle de Banikaora. Une journée de réflexion sur la supervision des ASBC a été réalisée avec l'EEZ de Banikoara	Les réunions régulières des EEZS ne sont pas encore rentrées dans les habitudes.
Résultat 1.3: Améliorer les procédures de collecte des données pour les indicateurs de santé familiale	Elaborer avec la DDS et les EEZS un tableau de bord ou PMP pour la gestion de la zone sanitaire	Une première ébauche d'un tableau de bord a été discutée au CODIR avec la proposition des normes essentielles à utiliser pour la supervision et mesure de la performance des agents pour 3 prestations clés.	Le draft du tableau de bord a été soumis à la DDSP pendant le 2nd trim La DDSP n'a pas encore fait les corrections et le feedback sur les remarc des médecins vis à vis du tableau de bord.
	Adapter les outils du SNIGS à l'offre intégrée de services du PMA de SF --- à ajouter au tableau de bord des zones.	Activité réalisée (voir réalisation précédente)	Fait, voir activité précédente
	Superviser la collecte des données, l'analyse et utilisation (monitoring,supervision, mini CAP) trimestriellement et/ou semestriellement	Quatre indicateurs sont mesurés à la fin de chaque trimestre et 3 à la fin de chaque semestre dans les 94 CS du Borgou Alibori par une équipe conjointe PROSAF/DDSP.	Les 4 indicateurs du PMP mesurés à la fin de chaque trimestre dans les ' du Borgou Alibori sont: Indice de Performance du COGEC; Disponibil Services à Base Communautaire; Indice de rupture de stock de produits santé familiale; Indice de Performance du système de supervision. Les indicateurs du PMP mesurés à la fin de chaque semestre dans les mêmes sont : Indice de Performance de l'EEZ; Prévalence des Services de Santé Familiale Intégrés; Score de Planification de la Zone Sanitaire.

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
	Former la DDS et les EEZS à l'archivage des documents (Matériel d'archivage par centre)		Cette activité n'a pas été programmée par la DDSP.
	Assistance technique et formation pour renforcer le SEPD dans la collecte, l'analyse et la retro-information du SNIGS	Plusieurs éléments de renforcement du SEPD ont été introduits ce trimestre: un abonnement pour le email etait sous scrit , une discussion sur la possibilité d'une sorte de site web pour la partage des base de donnees et documentation a eu lieu, le renforcement dans la publication RETRO-SNIGS est suggerer en combinant les efforts de LIEN-INFO pour en faire un bulletin trimestriel de la DDSP et ses partenaires	Un plan de travail sera organisé avec le SEPD.
Résultat 1.4: Revue des plans du Ministère de la Santé pour la décentralisation des pouvoirs et **Résultat 1.5 : Mettre en place un système de coordination et jouer un rôle de leadership pour une gestion coordonnée des activités de santé financées par l'USAID dans le Borgou et l'Alibori** **Résultat 1.6: Participer au développement des plans de travail des projets de santé dans le Borgou et l'Alibori**	Atelier pour informer les EEZS et le comité de santé sur leurs droits et leurs devoirs **(*voir l'atelier resultats 5.3)***	Participation de PROSAF à l'atelier de développement des critères de fonctionnalité des Zones et comité de santé	Ces critère seront utilisés à la formation des EEZs et Comités de Santé s leurs droits et leurs devoirs.
	Réunion mensuelle des partenaires de la DDSP	Ces réunions garde leur regularité est utilité pour la coordination et prioritisation des activités dans le court-terme. (voir annexe pour compte-rendu abréger de ses rencontres)	Les Partenaires étaient aussi en congé pour une bonne partie du trimestr
	CODIR élargi départemental		Cette rencontre n'a pas eu lieu au cours du troisième trimestre à cause d perturbations liées à l'épidémie de choléra.
	Comité Départementale d'Evaluation et Suivi des Projets		Cette activité a été reportée à une date ultérieure.
	Comité de suivi semestriel de la DDSP		Le comité de suivi semestriel des programmes et projets de la DDSP n'a lieu au début de l'année du fait des perturbations liées aux élections et fa temps au 2ième trimestre. Le MSP a mis sur pied un comité de suivi po chaque programme.
	Retraite avec la DDSP		Cette activité a été reporté a une date ultérieure.
	Suivre la mise en œuvre des activités conjointes avec les partenaires financés par USAID ***voir les activités surtout dans les volets 2, 3, 4 et 5***	La planification de l'utilisation des protocoles SF fait avec PRIME; les discussions avec BASICS se poursuit pour une transition des activités cette année; projection des prochaines étapes pour l'avancement du PCIME avec PROLIPO; consultation avec AFRICARE pour les noms des ONGS capables de faire les formations des CLV et CVS; collaboration avec World Education pour les séances de sensibilisation sur le SIDA dans les écoles avec l'ONG CAEB;	

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
Volet II : Amélioration de l'Accès aux Services et Produits de SF/SMI/MST/VIH			
Résultat 2.1: Aider le Ministère de la Santé à développer un système national de gestion de la logistique	Appuyer la création du dépôt départemental MEG/PC/Vaccins	L'étude de faisabilité du dépôt départemental est réalisée. La table ronde des partenaires pour le financement du dépôt a été réalisée et les principaux bailleurs ont exprimé leurs intentions de financement. Une requête officielle du MSP leur a été envoyée sur leur demande. Le site d'implantation du dépôt a été visité par la CAME, la DIEM/MSP et le DDSP, et les dossiers de soumission pour la construction du dépôt dépouillés.	
	Séances de travail avec commission restrainte pour intégrer le système de logistique et d'approvisionnement dans les zones sanitaires	Un Stock Zonal de Produits de SF a été créé à Banikoara	Ceci a été possible grâce aux négociations avec l'EEZ de Banikoara. C'e solution contre les ruptures de stock de produits de SF enregistrées au ni des CCS et ASBC.
Résultat 2.2 : Améliorer l'approvisionnement et la distribution des produits à travers le Borgou et l'Alibori	Séances de travail sur site pour indicateurs composites pour assurer le suivi et l'évaluation du système de gestion de la logistique	Quatorze séances de travail sur site ont eu lieu dans 7 CCS des Zones Sanitaires de Sinende Bembèrèkè, Malanville Karimama	Prosaf continuera d'utiliser les indicateurs composites (en cours de révis par DELIVER) comme des normes de gestion de la logistique pour ame équipes de santé à auto évaluer la performance de leur système logistiqu
	Appliquer les techniques d'amélioration du processus à la logistique avec les équipes AQ dans les zones	L'analyse des problèmes de rupture de stock de produits de santé familiale et l'identification de solutions appropriées a été faite dans 21 CCS selon l'approche de résolution rapide de problème.	Cet exercice a eu lieu dans les ZS Sinende Bembèrèrè, Malanville Karir et Nikki- Kalalé Pèrèrè. Il s'agit d'une adaptation de la démarche de rés rapide de problème en équipe car toutes les étapes n'ont pas été respecté
Résultat 2.3 : Etendre la disponibilité d'un paquet intégré de services de Santé Familiale pour le secteur public et privé	Utiliser l'AQ et d'autres techniques pour renforcer l'intégration au sein des cliniques publique et privées : Les visites terrain et les suivis	L'intégration a été renforcée dans 21 CCS en utilisant l'AQ et dans 7 CCS en utilisant l'approche tutorat	Les difficultés sont analysées avec les agents, les solutions identifiées et mise en œuvre microplanifée. En général le processus de résolution de problème en cours dans les 21 CCS des 2 zones de concentration a contr au renforcement de l'intégration des SSF.
	Identifier les besoins en personnel à former, équipement, réaménagement des espaces pendant visites terrain et les CODIR élargis départemental	Les paravents destinés au réaménagement des espaces de prestation ont été distribués dans les CCS sélectionnés pour démarrer l'intégration. Un 2ème recensement des besoins en équipement des CS a été réalisé et la commande des matériels médico techniques faite.	Le but visé est de complété le matériel médico technique mis en place p PROSAF pour renforcer la capacité des CS à offrir des SSFI.
	Former les prestataires sur le contenu de l'intégration des services (définition, organisation de l'intégration, mise en œuvre, gestion)	Réalisée dans les ZS Bembèrèkè Sinendé, Banikoara et Malanville Karimama	(Voir les formations / activité 3.2 sous volet 3)

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
	Assurer le coaching des AS et EEZS et développer les attitudes favorables et le réflexe chez les prestataires pour intégration	Neuf tuteurs ont commencé le coaching dans 11 centres de santé sur les 22 sélectionnés.	
	Soutenir les stages des AS à la polyvalence dans les hôpitaux confessionnels		Du fait des séries de formation en cours, cette activité est reportée en 20
	Atelier pour finaliser et vulgariser les guides PMIS (outils aide mémoire)	Guides finalisés et intégrés dans le "curriculum intégré" pour la formation à l'utilisation des protocoles	Cette activité a été intégrée au processus de formation des prestataires à l'utilisation des protocoles
	Atelier et suivi pour aider les EEZS à mettre en place un système de référence et contre référence avec l'HZ	i) Dans la ZS Bembèrèkè Sinendé, analyse des fiches de référence et contre référence pour leur amélioration et élaboration de cahier de charge pour l'utilisation de l'ambulance ii) renforcement de la prise de décision concernant les références avec l'utilisation des protocoles dans les ZS ciblées iii) au niveau départemental, consensus obtenu sur l'utilisation d'un système de téléphone fixe/mobile	L'atelier de mise en œuvre du système de référence et contre référence s'appuiera sur ces acquis
Résultat 2.4 : En collaboration avec PSI et d'autres partenaires développer et mettre en œuvre une stratégie pour accroître la distribution des produits de santé familiale au niveau communautaire dans le Borgou et l'Alibori	Développer des stratégies CCC complémentaires à PSI à travers les discussions et planifications		Il reste à développer des activités sur le terrain (cf résultat 4.2)
	Compléter la base de données des points de distribution avec PSI		La base de données des points de distribution des produits SF sera mise de façon routinière avec les ASBC et les FC
	Commander et distribuer l'équipement complémentaire des ASBC	Trois cent cinquante ASBC des zones de concentration et de non concentration disposent actuellement d'un minimum d'équipement (caisse, sac, mannequin boite à image PF, support de données, MEG et ou contraceptifs)	Il reste à fournir aux ASBC l'année prochaine un complément en boite à sur le paludisme, la nutrition, les MST/SIDA et en MEG et contraceptifs Bembereke et la zone de non concentration.
	BASICS: atelier adaptation curriculum ASBC pour le PMA/nutrition plus formation des formateurs départementaux.	Le module sur le PMA/nutrition a été adapté et intégré au curriculum de formation des ASBC. Les formateurs départementaux ont également été formés à l'utilisation de ce module	La formation des formateurs superviseurs et des ASBC sur le PMA/nutr aura lieu en 2002 et sera intégrée aux autres modules
	Suivre par la supervision la collecte des données routines sur les SBC	Le suivi de la collecte des données sur les SBC a été réalisé de façon intégrée à la supervision.	Le traitement informatique et l'analyse des données reste un point faible système sur lequel il faudra travailler l'année prochaine.

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
	Deux Formations des formateurs ASBC de la 2ième vague en 1er paquet services y incluant la supervision (CARE et PROLIPO)	Deux sessions de formation de 45 formateurs ont été réalisées	Quatre-vingt trois formateurs/superviseurs des ASBC dont 24 FAC et A présentement formés et disponibles dans le Borgou et l'Alibori
	Huit formations des ASBC du 2ieme vague	Neuf sessions de formation ayant regroupées 125 ASBC dans la zone de concentration et 9 autres sessions de formations ayant regroupées 127 ASBC dans la zone de non concentration on été réalisées	Trois cent cinquante ASBC sont aujourd'hui formés, équipés et fonction dans les zones de concentration et de non concentration
	Recyclage des ASBC du 1er vague		Ces recyclages seront combinés au complément de paquet des services e rapport avec la PCIME et les SONU
	Supervision et suivi régulier des ASBC	Cinq visites de supervision ont été réalisées à Banikoara 3 supervisions ont été réalisées à Bembereke-Sinende et 3 supervisions ont été réalisées dans la zone de non concentration	Cette disparité selon les zones s'expliquent par le fait que les activités n' démarré en même temps. La norme après 6 mois de fonctionnement est supervision au moins chaque 2 mois
	Trois Formations des formateurs 2ieme paquet de services incluant la PCIME et les SONU (PROLIPO et CRS)		Ces sessions auront lieu l'année prochaine. Le matériel de formation ser adapté au cours du 4ème trimestre.
	Dix-huit Formations des ASBC 2e paquet de services incluant la PCIME et les SONU et recyclage (PSEO et PROLIPO et CRS)		Ces sessions auront lieu l'année prochaine. Le matériel de formation ser adapté au cours du 4ème trimestre.
Volet III : Amélioration des Capacités des Agents de Santé à Offrir des Soins et Services de Qualité			
Résultat 3.1 : Aider le Ministère de la Santé dans l'adaptation et le pré test de la PCIME en collaboration avec BASICS	Identifier des sites pilotes de formation pour la PCIME et étudier les solutions d'acceptation possibles	Quarante-quatre sites pilotes dans trois Zones Sanitaires (Kandi-Gogounou-Segbana; Parakou-N'Dali; Tchaourou) ont été identifiées pour démarrer la mise en œuvre de la PCIME dans le Borgou Alibori.	Ces trois zones ont remplacé les deux zones de Banikoara et Bembereke/Sinende initialement sélectionnées
	Coordonner avec PROLIPO / AFRICARE et CRS les interventions communautaires et lancement PCIME *(voir les curriculum ASBC et autres agents relais de BASICS)*	Une microplanification conjointe des interventions PMA/Nut et PCIME communautaire PROSAF/ BASICS dans 9 Zones Sanitaires y compris les zones de concentration de PROSAF a été faite. Son exécution a démarré en Décembre 01 dans les deux zones de concentration de PROSAF	

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
	Formation des formateurs PCIME avec PROLIPO	Trois (3) formateurs départementaux (C/SSF et 2 pédiatres) ont été formés au niveau national à la technique de formation en PCIME. Puis dans une seconde phase les deux (2) pédiatres du groupe ont été formés en technique de facilitation clinique.	Cette dernière formation était organisée par la DDSP de l'ouémé.
	Formation des AS dans les sites pilotes en PCIME clinique	Un Plan départemental de formation des AS en PCIME clinique dans les sites élaboré	Le plan de mise en œuvre de la PCIME dans les sites pilotes ne démarr qu'en février 2002.
	Former les équipes des sites pilotes AQ (curriculum intégré et formation par tutorat)		Le plan de mise en œuvre de la PCIME dans les sites pilotes ne démarr qu'en février 2003.
	Former les tuteurs à la formation par tutorat	Neuf (09) tuteurs et 02 tuteurs / formateurs ont été formés à l'approche a la formation, aux outils du tutorat et a l'utilisation des protocoles de SF en juillet 01	
	Développer un plan d'extension de la formation sur la PCIME dans le reste du Borgou et l'Alibori		Le test pilote n'ayant pas encore démarré, pour les trois zones sélectionr ce plan ne sera développé qu'au 4ème trimestre 2002.
Résultat 3.2: Assister le Ministère de la Santé dans l'expansion du rôle des sages-femmes en y incluant des dispositions relatives aux Soins Obstétricaux et Néonatals d'Urgence (SONU) avec l'assistance de l'USAID à travers le projet PRIME	Identifier des sages-femmes et des infirmiers pour la formation SONU	Vingt-cinq (25) sages femmes et infirmiers ont été identifiés pour la formation en SONU dans les deux Zones de concentration. Les Besoins de formation en SONU ont été identifiés dans les deux zones. Les plans globaux en SONU élaborés par les deux zones sanitaires. Le Plan opérationnel SONU élaboré par la zone de Bembereke/Sinende.	Banikoara a estimé que son plan opérationnel 2001 était suffisamment c
	Travailler avec Prime pour développer des curriculum « in service » de formation basés sur des curriculum « pre service » de formation	Un curriculum de formation au PMSSFI avec un volet « femme » a été élaboré en juin 2001 avec la collaboration de Prime, DSF et la coordination nationale pour le tutorat.	
	Deux Formations des sages-femmes et infirmiers en soins d'urgence et AQ/GQ (curriculum intégré)	Quatorze sages-femmes et cinq infirmières responsables de maternité ont été formés sur des aspects de la prise en charge des soins d'urgence.	
	Suivi des formations	Deux visites de suivi ont été faites aux 11 tuteurs formes.	

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
	Intervention communautaire SONU à déterminer avec PRIME : atelier de planification et atelier d'analyse des résultats (dans les zones de concentration - les suivi sont inclus dans les suivis trimestriels)	Un atelier de planification des interventions communautaire a été réalisé avec la zone sanitaire de Malanville Karimama. Une première session de formation des FaC SONU a été réalisée à Malanville. La tenue de 33 réunions villageoises est en cours	Le CRAMS, l'Animatrice de GUENE et l'Animateur de Zone ABPF constituent l'équipe des FaC
Résultat 3.3 : Disséminer les normes, standards et protocoles de santé familiale auprès des agents de santé	Disséminer les protocoles SF à travers la formation au PMS intégré (***voir les formations curriculum intègre)***	Cinquante-sept (57) prestataires de services de santé familiale provenant de 22 centres de santé des trois zones identifiées pour le test des protocoles ont été formés à l'utilisation des protocoles de services de santé familiale (curriculum intègre) et au tutorat et suivi régulièrement par les tuteurs nationaux et départementaux	
	Assurer l'application des protocoles à travers la supervision	Quatre (04) supervisions formatives ont été effectuées pour les tuteurs et 01 pour les prestataires formés. Ces visites de supervision ont permis de constater que 11 centres de santé appliquent les protocoles de services de SF	
Résultat 3.4: Évaluer tous les besoins de formation des prestataires du secteur public et privé et développer un plan pour rassembler ces besoins	Atelier pour l'élaboration d'un plan annuel de formation départemental et zonal (avec le comité de suivi et formation continue)	Plan annuel de formation départemental et zonal 2001 élaboré	Le plan n'a pas été discuté avec la DDSP jusqu'à ce jour, mais les stand formation ont bel et bien été distribués.
	Participation aux réunions de consensus, de planification avec PRIME (pour SONU et protocoles /SF)	Trois sessions de planification des formations test en utilisation des protocoles des services de SF et des interventions SONU en collaboration avec PRIME ont eu lieu respectivement dans les ZS de Malanville Karimama, Banikoara et Sinende Bembèrèkè.	Cette activité a été "suspendue" compte tenue des plans opérationnels cl des zones sanitaires (surtout la zone sanitaire de Banikoara.)
	Ateliers et séances de travail de préparation du curriculum intégré incluant le PMIS et AQ plus gestion (avec l'équipe départemental de formateur -- prep avec les consultants)	Le curriculum a été élaboré en février 2001 avec la collaboration d'une consultante internationale	Ce curriculum a été adapté en juin 2001 avec la collaboration de PRIME et la coordination nationale pour le tutorat.
	Formations AS a l'utilisation des protocoles /SF	Quarante-deux (42) prestataires de services ont été formées en deux sessions exécutées par les formateurs de l'équipe départementale appuyés par des personnes ressources sous la supervision de la spécialiste en formation de PROSAF.	La validation du titre de formateur étant toujours en cours.

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
	Tester le curriculum intégré dans les zones de concentration (pilote)	Le curriculum a été testé 3 fois (sur les tuteurs, et deux groupes de prestataires)	
	Etendre l'utilisation du curriculum intégré		L'extension se fera en 2002.
	Former la DDS dans la gestion efficace et efficiente de l'utilisation du temps au cours de la retraite		La retraite qui devait se tenir au 2ème trimestre n'a pas encore eu lieu .E reportée au 1er trimestre 2002.
	Formation en technologie contraceptive (pour les zones sanitaires Niki/Kalale/Perere et Tchaourou) y compris le DIU	Trente-six (36) prestataires de services des zones sanitaires de Ndali/Parakou, Bembereke/Sinende et Tchaourou ont été formés	
	Formation en Prévention des infections	Neuf (09) tuteurs et 22 prestataires de 12 CCS de la zone sanitaires de Banikoara ont été formés aux principes et techniques de prévention des infections.	
Résultat 3.5: Mettre en place une équipe régionale de formation avec les aptitudes nécessaires en matière de formation	Une formation "in-service" à l'équipe régionale de formation sur les compétences en élaboration des curricula et, méthodes novatrices de formation		Cette activité a été pour 2002 et sera conduite avec la collaboration d'un consultante internationale.
Résultat 3.6: Développer de nouvelles voies pour accroître les niveaux de connaissance des agents de santé en santé familiale en prenant en compte l'accès et l'échange faciles des informations sanitaires et techniques	Recherche Opérationnelle sur les nouveaux moyens d'accroissement des connaissances des protocoles SF(formation classique / avec aide mémoire, formation à distance, formation par tutorat) ***avec PRIME***	Des données de base ont été collectées pour permettre de suivre l'évolution des connaissances en santé familiale des agents de santé. Les matériels de formation et les outils de suivi et évaluation ont été développés avec la collaboration de PRIME et la formation selon les techniques novatrices se fera au mois de juillet.	
	Par les visites sur les terrain assurer le coaching des AS et EEZS et Développer les attitudes favorables et le réflexe chez les prestataires pour intégration	Trois hôpitaux de zone, 4 CS et un centre communal urbain ont bénéficie de visite de coaching qui ont permi de constater que 11 agents de santé appliquent l'intégration	Les AS pratiquant l'intégration ont l'impression d'avoir un travail supplémentaire en offrant différent services le même jour contrairement qui se pratiquait avent la formation.

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
	Faire des formations sur le tas des activités du PMI des services avec les EEZS pendant les visites terrain et suivis		Pas d'activité spécifique ce trimestre
Résultat 3.7: Assister la DDS à développer un plan de supervision formative pour les agents de santé des Départements du Borgou et Alibori	Séances de travail pour la préparation de la formation en supervision	Activité réalisée avant chaque session de formation des EEZs	
	Former l'équipe de la DDS et les EEZS aux techniques de supervision formatives	Vingt-deux (22) membre EEZs des 7 Zones Sanitaires du Borgou Alibori ont été formées à la technique de supervision formative. Deux membres de la DDSP ont été des encadreurs au cours de cette formation. Le curriculum de formation en supervision formative (le manuel du participant, le manuel du formateur, le manuel de référence et les outils de supervision) sont finalisés	Reste quelques EEZS et membres de l'équipe de la DDSP a former.
	Mettre en œuvre et contrôler le système de supervision amélioré avec les compétences des EEZS en coaching pour assurer le monitorage des performances de qualité		Les EEZS n'ont pas encore été formés en coaching et en monitorage de l qualité des soins et services de santé.
Résultat 3.8 : Développer un système de monitoring de la formation et la performance des agents de santé.	Constituer des équipes d'AQ au niveau communautaire et zonal (avec les suivis des formations en AQ)	Vingt et un (21) EAQ ont été constituées. Pour lr suivi des EAQ, cfr. Resultats 5.2.	
	Former les équipes en AQ avec les nouveaux protocoles intégrés	Deux équipes à Banikoara et une équipe à Bembereke ont été formées.	
	Suivi et évaluation de la mise en œuvre du PMIS		Le suivi se fera à partir du prochain trimestre en même temps que la for des équipes aux nouveaux protocoles intégrés

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
Volet IV : Augmentation de la Demande et de l'Utilisation des Services et Produits de SF/SMI/MST/HIV/SIDA et Mesures Préventives			
Résultat 4.1 : Conduire une recherche formative et qualitative pour identifier des stratégies et messages appropriés	Faire des interviews approfondies et des focus groupes pour combler les vides et les priorités locales en matière de questions sanitaires ; identifier les voies souhaitées de réception de l'information en association avec les équipes AQ	L'enquête CAP complémentaire sur l'AME a été faite. Le rapport est finalisé. A partir des résultats d'enquêtes CAP et prise de décisions les comportements pour lesquels la recherche de déterminants est nécessaire ont été identifiés. Conduite d'une étude qualitative consistant en focus groupe et portant sur: - la CPN dans la ZS de Bembbèrèkè / Sde; - la vaccination dans la ZS de Banikoara; - la PF dans les 2 ZS précédentes et à Kandi.	Les thèmes choisis ont été identifiés par les équipes de résolution rapide problèmes et correspondaient aussi à ceux mis en exergue par l'enquête et l'enquête prise de décision.
	Un atelier pour élaborer des interventions de CCC	La stratégie de CCC a été élaborée selon une approche multimédia qui met l'accent sur la radio, les MPT, la CIP, les matériels imprimés. La formation, la supervision, la collaboration intersectorielle et la coordination ont été aussi prises en compte dans le document de stratégie Tenue de l'atelier de détermination des composantes durables IEC/CCC à partir du plan stratégique CCC.	
	Formation ASBC pour mini-CAP	Cent trente (130) ASBC ont été formés pour la collecte des données dans le cadre du mini CAP et les données ont été effectivement collectée auprès de xxx ménages.	
	Eude mini-CAP	La collecte et la saisie des données sont terminées. Les résultats bruts sont soumis.	
Résultat 4.2 : Elaborer et tester des matériels et messages spécifiques sur des thèmes de planification familiale utilisant par exemple les média traditionnels (danseurs, crieurs publics, griots) en information, éducation et communication	Atelier de conception de supports de communication avec les artistes	Tenue de 3 ateliers avec pour résultats 27 cartes conseils conçues comme matériels imprimés pour lutter contre le paludisme	La disponibilité de matériel imprimes sur la PF a fait réorienter cette act sur le paludisme. Une restitution a été faite a tous les partenaires du proc Les représentants du MSP ont souhaite qu'une restitution soit faite (en 2 aux hautes autorités du MSP avant la mise en œuvre au plan national.
	Mini Campagnes (événements pour les journées mondiales ou nationales sélectionnées)	Deux mini campagnes ont été réalisées: - La campagne de lutte contre l'épidémie de choléra qui a frappé la ville de Parakou et alentours - La campagne de lutte contre le SIDA dans le cadre de la journée Mondiale de lutte contre le SIDA Contribution financière à la campagne pour les JNV	Le quatrième trimestre a été consacré aux JNV, Services intégrés de san Familiale, Journée Mondiale de lutte contre le SIDA.
	Atelier de formation des formateurs des MPT en élaboration de messages.	Une équipe de 5 personnes par zone sanitaire pour les 7 zones ont été formées à l'utilisation des MPT et à l'élaboration des messages.	Réalise au 2eme trimestre

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
	Atelier de formation / recyclage des média populaires en élaboration des messages	Atelier organisé par la ZS de Banikoara	Cette activité se fera par zone sanitaire. PROSAF contribuera au finance La programmation est laissée à chaque zone sanitaire; un suivi est fait p PROSAF.
	Présentations : les campagnes MPT		Cette activité qui se fera par zone sanitaire est re programmée pour 4èm trimestre 2001 et 1er trimestre 2002.
	Ateliers pour coordonner la presse et les radios locales pour concevoir 2- 6-8 semaines de campagne pour appuyer le travail des réseaux de média populaires et traditionnels	Tenue de 2 atelier bilan et programmation des thèmes avec les radios locales du Birgou et de l'Alibori.	
	Contrats à renouveler avec les radios (a ajouter 2 autres radios pour faire 4 au total - Banikaora, Bembereke, et ex: Nikki, Denam		
	Concevoir et diffuser un feuilleton radio	Acquisition de 2 feuilletons radio "la vie n'est pas compliquée et les clés de la vie" Elaboration en cours par un artiste local d'un feuilleton: C'est ça	Les feuilletons acquis ont été réalises respectivement par les projets PRI (Guinee) et SFPS (Cote d'Ivoire)
	Produire du matériel de communication (affiches , cassettes audio, dépliants, K7 vidéos) à distribuer dans les centres de santé	Production d' une cassette audio relative à la PF et aux mesures de protection des enfants contre les maladies dont 15 exemplaires distribuées dans les CS de Banikoara et 4 radios locales. Multiplication en 80 exemplaires de la cassette de l'artiste Djollus Djollas sur la lutte contre le SIDA et distribution dans les 4 radios locales et dans tous les centres de santé de la zone de concentration. Production des dépliants, affiches, fiches posologie et cartes conseils pour lutter contre le paludisme.	D'autres productions viendront s'ajouter à celles déjà produites. Il s'agit imprimés, spots radio, feuilletons.
Résultat 4.3 : Inclure l'IEC et le counseling dans tous les cours de formation continue et formation de base	Formations des EEZ en intervention CCC et CIP (ou gestion des conflits)		Reprogramme pour 2002
	Intégrer IEC/CCC à la formation continue et intégrée existante à travers les ateliers et les supervisions: il s'agit d'une activité continue.	Ce travail a commencé avec la formation des tuteurs à Sinendé. Ce travail se fait aussi dans les 2 zones de concentration par les responsables IEC. Voir volet 3	

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
Résultat 4.4 : En collaboration avec BINGOS, HEPS et d'autres projets, organiser les ONG locales à former les agents sociaux, les agriculteurs en IEC santé	Atelier d'adaptation des outils de supervision pour ASBC / IEC avec les ONGs (CARE-ROBS) Poursuivre et fournir une assistance supplémentaire si besoin: 2 visites de suivi de 3 personnes pendant 3 jours		Activités du résultat 4.4 supprimés
Résultat 4.5 : Inclure les activités d'IEC dans des programmes opérationnels de développement à base communautaire	Pendant les suivis / visites terrains informer d'autres groupes sur les ressources IEC disponibles; les assister à développer les activités (surtout les AZ dans les zones de non concentration)		Activité continue et intégrée sur le terrain, exécutée par les volets 4 et 5
Résultat 4.6 : Élaborer et poursuivre un plan d'accroissement de la capacité des agents de santé à développer, communiquer et mesurer l'impact des messages IEC	Atelier de détermination des composantes durables IEC à partir du plan stratégique BCC. Deux (2) formations des agents en techniques et outils de communication et évaluation des messages:	Atelier fait avec le Noyau et composantes identifiées (recherche, formation, radio, MPT, matériels imprimés, campagnes)	Rencontre souhaite avec d'autres partenaires sur le plan stratégique BCC d'enrichir ce qui est propose par le Noyau Reprogrammees pour 2002
Volet V : Renforcement de la Participation Communautaire			
Résultat 5.2: Faire le suivi d'autres paquets de résultats avec les centres de santés et communautés choisies, tels la formation et les	Faire le suivi continu des plans d'action de CCS/COGEC/COGES/CVS y compris des activités d'Assurance Qualité au niveau des communautés, des AGR et des activités de CCC	Le suivi de la mise en œuvre des 21 plans d'action par les COGEC a été réalisé avec un accent particulier sur la tenue régulière des réunions ordinaires et la résolution des problèmes de santé en équipe. Toutes les 21 équipes de résolution de problèmes sont à l'étape de la mise en œuvre des solutions.	Les activités de promotion de la santé et l'intégration des activités des M plan budget des CCS ont constitué les maillons faibles de la chaîne en 2

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
activités IEC en santé familiale, santé environnementale et les mesures de prévention.	Vingt-trois (23) ateliers communautaires de revue a mi parcours des plans et de financement des AGR	Vingt et un (21) ateliers de revue à mi-parcours des plans d'action des CCS ont été réalisés. La revue à miparcours à révélé un taux moyen de réalisation de 65%% des plans de CCS. Cependant les activités d'ordre promotionnel et éducationnel n'ont été exécuté qu'à 30%.	Le financement des activités de promotion dans les villages et la collecti données de base connaissent des difficultés. Des disposition sont déjà p pour que ce trimestre ces questions soient résolues en 2002.
	Quatre sessions périodiques de planification et de coordination des activités de terrain dans la zone de concentration	Les 4 sessions ont été régulièrement tenues avec la participation effective des personnes attendues.	
	Quatre (4) sessions périodiques de planification et de coordination des activités de terrain dans la zone de non concentration	Les 4 sessions ont été régulièrement tenues avec la participation effective des personnes attendues.	
	Mini CAP		Voir volet 2 et 4
	Faire le suivi des AGR		Les AGR ne sont pas encore mises en œuvre.
Résultat 5.3: Identifier les besoins de formation des COGES et COGEC et renforcer leurs capacités à gérer les ressources et s'impliquer davantage dans la prévention de la santé et des services "outreach"	Vingt-trois (23) ateliers d'évaluation et d'élaboration des PA/budget	Les 23 ateliers d'évaluation des PA/budget 2001 et d'élaboration des PA/budget 2002 ont été tenus et ont connu la participation de 562 personnes dont les membres COGEC, les AS, les ONG et les élus locaux.	Dans la zone sanitaire de Bembereke-Sinende l'UVS de Yara s'est doté plan d'action budget à part.
	Élaboration des critères de sélection des ONG pour la formation des CVS/CLV et sélection des ONG	Sept (7) ONG ont été sélectionnées sur 10 consultées. Un contrat de prestation de service a été discuté et signé avec chacune d'entre elles.	
	Adaptation des modules de formation des CVS/CLV	Le curriculum de formation des CVS et CLV a été élaboré et porte sur la gestion financière la programmation des activités la gestion des conflits le concept SBC, la tenue de réunion efficace et le contrôle de gestion.	
	Formation des formateurs (technicien des ONG) des CVS/CLV	Trente (30) formateurs de 7 ONG ont effectivement été formé en méthodologie de la formation selon les standards de PROSAF.	Les formateurs ont été répartis en équipe de 2 dans tout le département p assurer la formation de près de 1500 membres de comité villageois.

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
	Soixante-dix (70) sessions de formation recyclage des CVS/CLV	Soixante (60) sessions de formation ont été réalisées avec la participation de 1325 personnes soit un taux de participation de 90% malgré la période des travaux champêtres	Soixante (60) sessions au lieu de 70 se sont revellees suffisantes pour cc les besoins de formation
	Dix (10) sessions de formation des COGEC/COGES en gestion des ressources financières, matérielles et humaines		L'inexistence d'un manuel de procédures de gestion financière et administrative des FS a fait que ces formations ne peuvent pas se tenir a l'année 2002.
	Sessions de formation des COGEC, COGES en santé, tenue efficace de réunion, structuration et mise en œuvre des activités de promotion de la santé	Les membres des 21 COGEC et 3 COGES soit 223 personnes dont 167 membres de cogec et 19 agents de santé ont été formés à leur roles et responsabilités, à la tenue de réunion efficace puis à l'élaboration de leur règlement intérieur.	Toutes les sessions ont été réalisées sauf celles relatives a la structuratio activités de promotion de la santé. Elles seront réalisées en 2002 en collaboration avec le PBA et le MSP
	Pendant les visites de coaching et suivi développer les capacités des COGEC, COGES à la résolution des problèmes de santé familiale (Accueil, CPN, accouch à domicile) à travers la mise en œuvre de 84 cycles de résolutions de problèmes	Quatre-vingt six (86) membres de Cogec et 39 AS provenant de 21 FS ont été formés à l'approche rapide de résolution de problèmes en équipe. Vingt et un équipes de résolution de problèmes ont été constituée dans les CCS et ont reçu continuellement l'appui du programme selon leur plan de travail. Toutes ces équipes sont à l'étape de mise en œuvre des solutions	Un accent particulier devrait être mis le trimestre prochain sur le calcul indicateurs de base et la collecte des données de façon continue.
	Développer les capacités des CVS, COGEC, COGES à la coordination au sein de la communauté (à partir des suivis)	Les capacités des COGEC et COGES à coordonner les activités au sein des communautés ont été développées à travers l'évaluation et la micro planification des activités au cours des réunions mensuelles statutaires qui ont connu un taux moyen de réalisation de 65%	Le processus avec les CVS est prévu commencer le trimestre prochain
	Atelier et formations pour appliquer la stratégie de qualité design sur les normes d'accueil et les SONU.		Les équipes ne travaillant que sur la CPN et la vaccination, le qualité de sur les SONU sera fait l'année prochaine.
	21 rencontres de définition des mécanismes de motivation des acteurs de santé		Cette activité sera réalisée l'année 2002.

Résultats	Activités planifiées pour l'année	Réalisations au cours de l'année	Observations
	Ateliers pour informer et renforcer les comités de santé dans leur rôle d'administrateur des zones sanitaires	Deux cent cinquante-cinq (255) leaders communautaires (membres COGEC, elus communautaires membres de groupements villageois de la Zone sanitaire de Parakou Ndali ont été orientés sur la politique des zones sanitaires et ses implications.	La formation des comités de santé ne pourra se faire qu'en 2002.
Résultat 5.4: Recommander et financer les interventions durables au niveau communautaire utilisant de nouvelles approches pour accroître la participation communautaire dans les domaines de santé	Rencontres de restitution des propositions de financement des AGR		Un argumentaire justifiant l'importance de cette activité a été développé soumis à l'USAID. Cette activité ne prendra corps qu'en 2002 après approbation de USAID et URC.
	Atelier de consensus sur le modèle de financement des AGR avec les COGEC et EEZS		Sera programmé en 2002 si l'USAID donne son accord pour la mise en (des AGR dans le Borgou Alibori
	Vingt-trois (23) ateliers communautaires de mise en place et d'orientation des structures communautaires de gestion des fonds pour AGR		Les AGR n'ont pas encore commencé.
	Session de formation des FaC sur la structurations des AGR		Les AGR n'ont pas encore commencé.
	Douze (12) sessions de formation des bénéficiaires des financements à la gestion des AGR		Les AGR n'ont pas encore commencé.
	Octroie des financements		Les AGR n'ont pas encore commencé.
	Suivre le fonctionnement du système mis en place		Les AGR n'ont pas encore commencé.

7. PROSAF 2002 WORK PLAN

ACTIVITES	ANNEE 2002												RESP
	J	F	M	A	M	J	J	A	S	O	N	D	PRIN
Gestion du Projet													
Organiser un Atelier de team-building			x										TAF
Développer le plan de travail annuel détaille	x												TAF
Préparer les rapports trimestriels et annuel			x			x			x		x	x	TAF
Conduire le Monitoring des indicateurs du PMP			x			x			x			x	MS
Tenir les réunions mensuelles techniques et administratives du projet	x	x	x	x	x	x	x	x	x	x	x	x	TAF/MS
Tenir la réunion de mise à jour avec le staff du niveau central de l'ABPF sur le projet du Borgou/Alibori	x	x	x	x	x	x	x	x	x		x	x	TAF/AA
Tenir la réunion de programmation (PROSAF et DDSP)	x	x	x	x	x	x	x	x	x	x	x	x	TAF/MS
Organiser la revue à mi-parcours du programme par l'USAID/Bénin				x	x								
Volet I : Amélioration de la Planification et la Coordination													
Résultat 1.1: Développer et mettre en œuvre un plan pur accroître la capacité des agents de santé du Borgou aux niveaux départemental et des zones sanitaires													
Valider le plan de renforcement des capacités en gestion élaboré par la DDS/BA	x	x											TAF
Mettre en œuvre et suivre le plan de renforcement de la gestion à travers les requêtes pour programmations CODIR			x	x	x	x	x	x	x	x	x	x	TAF/MS
Organiser des sessions de formations et de coaching des équipes de gestion de la DDSP/BA et des Zones en matière de gestion de la qualité			x		x		x		x				MS/TK/TAF/ Consultant
Elaborer et mettre en œuvre des stratégies de gestion des ressources humaines afin d'améliorer la motivation et l'engagement des prestataires			x	x	x	x	x	x	x	x	x	x	TAF/MS
Réviser les outils et préparer et organiser l'EQGSS 2	x	x	x	x									MS/Consult ant
Organiser deux ateliers et deux sessions de coaching pour développer les compétences en leadership pour tous les niveaux (DDS, EEZ)			x			x			x			x	SK/Aimé
Appuyer techniquement les EEZS dans l'élaboration d'un manuel de procédures standardisé de gestion dans les ZS			x	x	x								MS
Organiser la formation des AS à l'utilisation du manuel de procédures standardisé de gestion dans les ZS						x	x	x	x	x			SK/Aimé
Organiser la réflexion sur la pérennisation des interventions du projet dans le Borgou/Alibori		x	x										TAF
Résultat 1.2: Développer des plans stratégiques et opérationnels en santé familiale en collaboration avec les partenaires publics et privés													
Conduire des Séances de coaching sur site de travail pour le développement des compétences des AS en planification, mise en place et évaluation des activités			x	x	x	x	x	x	x	x	x	x	MS/Aimé
Organiser deux ateliers de concertation et planification pour impliquer les responsables ZS dans le processus de planification des EEZS			x						x				Aimé
Identifier les besoins en ressources matérielles et assistance technique pour appuyer les EEZS dans la mise en œuvre de leurs PA budgétisés	x	x	x										Aimé
Faire un consensus et mettre en œuvre les procédures de gestion financières des Centres de Santé			x	x	x	x	x	x					TAF/TK
Participer aux séances de concertation avec les EEZS	x	x	x	x	x	x	x	x	x	x	x	x	MS
Appuyer la DDSP/BA dans l'élaboration de son plan stratégique 2003-2005										x	x	x	TAF/MS
Appuyer la DDSP/BA dans l'élaboration de son plan opérationnel 2003											x	x	TAF/MS
Participer à l'évaluation du plan stratégique 200-2002 de la DDSP/BA								x	x				MS
Résultat 1.3: Améliorer les procédures de collecte des données pour les indicateurs de santé familiale													
Adapter les outils du SNIGS à l'offre intégrée de services du PMA de SF				x	x	x							MS
Ameliorer l'utilisation des données pour la prise de décision a tous les niveaux			x			x			x			x	MS

Promouvoir l'utilisation de la technique de la naissance précédente pour le suivi de la mortalité infantile et maternelle			x	x	x	x	x	x	x	x	x	x	TAF/MS
Former la DDS et les EEZS à l'archivage des documents						x							MS/SK
Assister techniquement et former pour renforcer le SEPD dans la collecte, l'analyse et la retro-information du SNIGS			x			x			x			x	MS
Actualiser et renforcer l'utilisation du tableau de bord		x	x		x	x		x	x		x	x	MS
Résultat 1.4: Revue des plans du Ministère de la Santé pour la décentralisation des pouvoirs et responsabilité et application des politiques de décentralisation													
Organiser un atelier d'information des EEZS et le CS sur leurs droits et devoirs		x											MS/TK
Résultats 1.5 et 1.6: Participer au développement des plans de travail des projets de santé dans le Borgou et l'Alibori et Participer au développement des plans de travail des projets de santé dans le B/A													
Participer aux staffs hebdomadaires de la DDSP	x	x	x	x	x	x	x	x	x	x	x	x	TAF/MS
Participer à la réunion mensuelle des partenaires de la DDSP	x	x	x	x	x	x	x	x	x	x	x	x	TAF/MS
Participer au CODIR élargi départemental			x			x			x			x	TAF/MS
Participer aux réunions du Comité Départementale d'Evaluation et Suivi des Projets			x			x			x			x	TAF/MS
Organiser une Retraite avec la DDSP			x										TAF/MS
Elaborer et mettre en œuvre le MOU entre le Projet, USAID et la DDSP/BA			x	x									TAF/MS
Suivre la mise en œuvre des activités conjointes avec les partenaires financés par USAID (BASICS et PRIME)	x	x	x	x	x	x	x	x	x	x	x	x	TAF/MS
Participer au développement d'un plan d'action conjoint des partenaires financés par l'USAID en matière de santé										x			TAF/MS
Volet II : Amélioration de l'Accès aux Services et Produits de SF/SMI/MST/VIH													
Résultat 2.1: Aider le Ministère de la Santé à développer un système national de gestion de la logistique													
Appuyer la création et le fonctionnement du dépôt départemental MEG/PC/Vaccins			x	x	x	x							MS
Tenir des Séances de travail avec commission restreintes pour intégrer la SLA dans les ZS		x			x			x			x		MS
Résultat 2.2 : Améliorer l'approvisionnement et la distribution des produits à travers le Borgou et l'Alibori													
Tenir des Séances de travail sur site pour assurer le suivi et l'évaluation du système de gestion de la logistique			x			x			x			x	MS
Appliquer les techniques de résolution rapide des problèmes à la logistique avec les équipes AQ dans les zones sujettes aux ruptures fréquentes de produits SF du B/A		x	x	x	x	x	x	x	x	x	x	x	Aimé
Mettre en place des dépôts répartiteurs de zones	x	x	x	x	x	x							MS
Participer à l'atelier régional sur la logistique PCIME au Sénégal						x							MS
Résultat 2.3 : Etendre la disponibilité d'un paquet intégré de services de Santé Familiale pour le secteur public et privé													
Poursuivre l'appui a l'intégration des services			x	x	x	x	x	x	x	x	x	x	Aimé/SK/ TAF
Utiliser l'AQ et d'autres techniques pour étendre l'offre des services intégrés au sein des cliniques publiques et privées	x	x	x	x	x	x	x	x	x	x	x	x	Aimé
Identifier les besoins en personnel à former, équipements, réaménagement des espaces pendant visites terrains et les CODIR élargis		x			x			x			x		SK/Aimé
Assurer le coaching des AS et EEZS et développer les attitudes favorables et le réflexe chez les prestataires pour l'intégration	x	x	x	x	x	x	x	x	x	x	x	x	SK/Aimé
Soutenir les stages des AS à la polyvalence dans les hôpitaux confessionnels				x	x	x	x	x	x	x	x	x	Aimé
Assurer le suivi des EEZS dans la mise en place d'un système de référence et contre référence avec l'HZ			x	x	x	x	x	x	x	x	x	x	MS/Aimé
Etendre le Norplant dans le Borgou/Alibori		x	x	x									MS/Aimé
Dynamiser le PEV	x	x	x	x	x								MS
Organiser un Voyage d'étude sur l'intégration en Guinée		x											TAF/MS

Résultat 2.4 : En collaboration avec PSI et d'autres partenaires développer et mettre en œuvre une stratégie pour accroître la distribution des produits de santé familiale au niveau communautaire dans le Borgou et l'Alibori													
Former 350 ASBC au paquet complémentaire d'activités(PMA Nutrition, diarrhée, CPN et Vaccination)		x	x										TK
Recycler 350 ASBC en Paludisme, PF et IST/SIDA										x	x		TK
Superviser et suivre régulièrement les ASBC	x	x	x	x	x	x	x	x	x	x	x	x	TK
Introduire la PCIME communautaire dans les sites pilotes		x	x	x									TK
Introduire les SONU communautaires à Malanville	x	x	x	x	x	x	x	x	x	x	x	x	TK
Fournir l'Equipement complémentaire des ASBC	x	x	x										TK
Organiser une Revue semestrielle des Services à Base Communautaire						x						x	TK
Participer à la conférence des ONG sur la PCIME communautaire au Sénégal	x												TAF/TK
Organiser un Voyage d'étude à Madagascar sur la PCIME communautaire							x	x					TAF/TK
Volet III : Amélioration des Capacités des Agents de Santé à Offrir des Soins et Services de Qualité													
Résultat 3.1 : Aider le Ministère de la Santé dans l'adaptation et le pré test de la PCIME en collaboration avec BASICS													
Former les formateurs des zones pilotes en PCIME avec PROLIPO		x	x										SK
Former les AS dans les zones pilotes en PCIME classique				x	x	x	x	x	x				SK/Aimé
Former les AS dans les zones pilotes en AQ et assurer le suivi des équipes AQ			x	x	x	x	x	x	x	x	x	x	Aimé/SK/ Consultant
Développer et valider un plan d'extension de la formation sur la PCIME dans le reste du Borgou et l'Alibori										x			SK
Intégrer la PCIME dans la grille de supervision et conduire les supervisions		x	x	x	x	x	x	x	x	x	x		SK
Résultat 3.2: Assister le Ministère de la Santé dans l'expansion du rôle des sages-femmes en y incluant des dispositions relatives aux Soins Obstétricaux et Néonatals d'Urgence (SONU) avec l'assistance de l'USAID à travers le projet PRIME													
Former et superviser les Sages Femmes des zones de concentration en SONU et AQ		x	x	x	x	x	x	x	x	x	x	x	SK/Aimé
Elaborer et valider le plan d'extension des SONUs aux autres formations sanitaires du Borgou/Alibori										x	x	x	SK/Aimé
Résultat 3.3 : Disséminer les normes, standards et protocoles de santé familiale auprès des agents de santé													
Disséminer les protocoles SF à travers la formation au PMS intégré (voir les formations curriculum intègre)		x											SK
Assurer l'application des protocoles à travers la supervision			x	x	x	x	x	x	x	x	x	x	SK
Résultat 3.4: Evaluer tous les besoins de formation des prestataires du secteur public et privé et développer un plan pour rassembler ces besoins													
Elaborer, valider et mettre en œuvre un plan annuel de formation départemental et zonal (avec le comité de suivi et formation continue)	x	x										x	SK
Former les Enseignants de l'ENIIAB en SF avec l'appui de JHPIEGO		x											SK
Elaborer, Tester et valider un curriculum intégré de SF adapté aux Accoucheuses villageoises et aux aides soignantes dans les zones de concentration (pilote)			x	x									SK/Aimé
Former et superviser les TBAs et les Aide-soignantes au curriculum intégré de SF					x	x	x	x	x	x	x	x	SK/Aimé
Résultat 3.5: Mettre en place une équipe régionale de formation avec les aptitudes nécessaires en matière de formation													
Organiser une formation "in-service" à l'équipe régionale de formation sur les compétences en élaboration des curricula et méthodes novatrices de formation	x	x	x										SK/Aimé
Planifier et suivre les formations de l'équipe départementale des formateurs dans le Borgou/Alibori				x	x	x	x	x	x	x	x	x	SK/Aimé
Résultat 3.6: Développer de nouvelles voies pour accroître les niveaux de connaissance des agents de santé en santé familiale en prenant en compte l'accès et l'échange faciles des informations sanitaires et techniques													
Continuer l'appui aux équipes AQ centres-de santé/communautés				x	x	x	x	x					TAF/SK
Assurer la documentation et la dissémination de meilleures pratiques testes dans les équipes AQ				x	x	x	x	x	x	x	x	x	TAF/MS/SK /TK

Résultat 3.7: Assister la DDS à développer un plan de supervision formative pour les agents de santé des Départements du Borgou et Alibori													
Former les EEZS et l'équipe de la DDSP/Borgou aux techniques de supervision formative	x		x										SK/Aimé
Mettre en œuvre et contrôler le système de supervision amélioré avec les compétences des EEZS en coaching pour monitorer les performances de qualité				x	x	x	x	x	x	x	x	x	Aimé/SK
Résultat 3.8 : Développer un système de monitoring de la formation et la performance des agents de santé.													
Actualiser la base de données des formations par la collecte et le traitement des données sur les formations organisées	x	x	x	x	x	x	x	x	x	x	x	x	SK
Elaborer des critères d'attribution et mettre en œuvre en collaboration avec le MSP et l'USAID, le "Cercle d'or de qualité" au CS modèle de l'année au Borgou Alibori				x	x			x	x		x		TAF/SK/ Consultant AQ
Participer à la Conférence Nationale sur l'Elaboration d'un Plan National en AQ au Rwanda			x										TAF
Volet IV : Augmentation de la Demande et de l'Utilisation des Services et Produits de SF/SMI/MST/HIV/SIDA et Mesures Préventives													
Résultat 4.1 : Conduire une recherche formative et qualitative pour identifier des stratégies et messages appropriés													
Faire des interviews approfondies et des focus groupes pour combler les vides et les priorités locales en matière de questions sanitaires; identifier les voies souhaitées de réception de l'information en association avec les équipes AQ (enquête CAP et qualitative)				x	x	x	x	x					SA/EA
Evaluer le contrat avec les radios de Banikoara et de Bembéréké				x	x	x							SA/EA
Elaborer des interventions de CCC			x	x									SA/EA
Résultat 4.2 : Elaborer et tester des matériels et messages spécifiques sur des thèmes de planification familiale utilisant par exemple les média traditionnels (danseurs, crieurs publics, griots) en information, éducation et communication													
Organiser un atelier de conception de supports de communication avec les artistes								x	x	x	x	x	SA/EA
Conduire des Mini-campagnes (événements pour les journées mondiales ou nationales sélectionnées)				x		x					x	x	SA/EA
Organiser un Atelier de formation/recyclage des média populaires: 1 séance de 32 personnes pour 3 jours par sous-préfecture.	x	x	x										SA/EA
Organiser des campagnes MPT	x	x	x							x	x	x	SA/EA
Organiser des ateliers pour coordonner la presse et les radios locales pour concevoir 8 semaines de campagne pour appuyer le travail des réseaux de média populaires et traditionnels		x				x				x			SA/EA
Renouveler les contrats avec les 5 radios-Banikaora, Bembéréké, Nikki, Denam, ORTB Parakou	x	x											SA/EA
Concevoir et diffuser un feuilleton par la radio		x	x	x	x	x	x						SA/EA
Produire du matériel de communication (affiches, cassettes audio, dépliants, vidéos) à distribuer dans les centres de santé	x	x								x	x		SA/EA
Résultat 4.3 : Inclure l'IEC et le counseling dans tous les cours de formation continue et formation de base													
Former les EEZ en intervention CCC et CIP				x									SA/EA
Intégrer l' IEC/CCC à la formation continue et intégrée existante à travers les ateliers et les supervisions des AS (il s'agit d'une activité continue)	x	x	x	x	x	x	x	x	x	x	x	x	SA/EA
Résultat 4.4 : En collaboration avec BINGOS, HEPS et d'autres projets, organiser les ONG locales à former les agents sociaux, les agriculteurs en IEC santé													
Résultat 4.5 : Inclure les activités d'IEC dans des programmes opérationnels de développement à base communautaire													
Informer d'autres groupes sur les ressources IEC disponibles et les assister à développer les activités (surtout les AZ dans les zones de non-concentration)	x	x	x	x	x	x	x	x	x	x	x	x	SA/EA
Résultat 4.6 : Elaborer et poursuivre un plan d'accroissement de la capacité des agents de santé à développer, communiquer et mesurer l'impact des messages IEC													

Déterminer lors d'un atelier les composantes durables IEC à partir du plan stratégique BCC			x	x									SA/EA
Former des agents de santé en techniques et outils de communication et évaluation des messages			x	x	x	x							SA/EA
Suivre et Appuyer la mise en œuvre du plan d'action du noyau IEC	x	x	x	x	x	x	x	x	x	x	x	x	SA/EA
Volet V : Renforcement de la Participation Communautaire													
Résultat 5.2: Faire le suivi d'autres paquets de résultats avec les centres de santés et communautés choisies, tels la formation et les activités IEC en santé familiale, santé environnementale et les mesures de prévention.													
Faire le suivi continu des plans d'action de CCS/COGEC/COGES/CVS y compris des activités d'Assurance Qualité au niveau des communautés, des AGR et des activités de CCC	x	x	x	x	x	x	x	x	x	x	x	x	TK
Organiser 23 ateliers communautaires de revue à mi-parcours des plans de financement des AGR						x							TK
Organiser 4 Sessions périodiques de planification et de coordination des activités de terrain dans la zone de concentration et de non concentration			x			x			x			x	TK
Résultat 5.3 : Identifier les besoins de formation des COGES et COGEC renforcer leurs capacités à gérer les ressources et s'impliquer davantage dans la prévention de la santé et des services "outreach."													
Organiser 23 ateliers d'évaluation et d'élaboration des PA/Budget										x	x		TK
Tenir 10 sessions de formation des COGEC/COGES en gestion des ressources financières, matérielles et humaines						x	x						TK
Organiser des sessions de formation des COGEC, COGES en structuration et mise en œuvre des activités de promotion de la santé			x										TK
Recycler les comités villageois de Santé					x								TK
Organiser des Sessions d'alphabétisation des CVS			x	x	x								TK
Organiser un voyage d'étude au Burkina pour les COGEC/COGES			x										TK
Organiser des ateliers pour informer et renforcer les comités de santé sur leurs rôles et responsabilités en matière de gestion de centres de santé					x	x							TK
Résultat 5.4: Recommander et financer les interventions durables au niveau communautaire utilisant de nouvelles approches pour accroître la participation communautaire dans les domaines tels la fourniture de services de santé, l'approvisionnement et la distribution des produits de santé, renforcement de la gestion des services de santé communautaire, promotion de la santé environnementale et prévention des maladies.													
Tenir des rencontres de restitution des propositions de financement des AGR	x												TK
Organiser un atelier de consensus sur le modèle de financement des AGR avec les COGEC et EEZS		x											TK
Tenir 23 ateliers communautaires de mise en place et d'orientation des structures communautaires de gestion des fonds pour AGR				x	x								TK
Organiser une session de formation des FaC sur la structurations des AGR						x							TK
Organiser 12 sessions de formation des bénéficiaires des financements à la gestion des AGR								x	x				TK
Octroyer des financements										x	x	x	
Suivre le fonctionnement du système mis en place										x	x	x	TK

ANNEX 1

Summary of PMP Indicators and Results for 2001

Evaluation de Performance Annuelle: Objectifs et Résultats

VOLET 1: Amélioration de la Planification et Coordination à Tous les Niveaux							Observations sur les indicateurs et la collecte de données
No.	**INDICATEUR**	**Source de Vérification**	**DONNEES DE BASE (1999)**	**Resultats 2000**	**Objectif 2001**	**Resultats annuel 2001**	
8	Score des zones sanitaires en planification (%)	SEPD/DDS EEZ, Rapport Comité de Sté	40 (EQGSS)	54	65	83	All the health zones have now gained a very good understanding of the improtance of equipping themselves with strategic fand annual plans, and of negotiating financing with partners. As a result, the objective set in 2001 (75%) for the health zone planning socer has been surpassed and is very close to the objective for 2002.
9	Performance des EEZS (%)	Rapport Activiés des EEZ, Interview/dicussio nsavec les EEZ - Archives Administration de la ZS	0 (EQGSS)	26	35	36	Health Zone Management Team Performance is progressing slowly because of the difficulties in developping health maps and in carrying out formative supervision on a regular basis. Beside these factors, some of the HZ Coordinators moved out the Department for Master in Public Health training or to another Department. However, the performance level in the 3rd quarter 01 is fairly close to the objective set for 2001 (40%). The challenge facing the DDSP is that of the quality of the plans developed and strengthening the capacity of the HZMTs and health care workers to provide better management and quality services based on the plans that have been developed.
VOLET 2: Amélioration de l'Accès aux Services et Produits de SF/SMI/MST/VIH							**Observations sur les indicateurs et la collecte de données**
No.	**INDICATEUR**	**Source de Vérification**	**DONNEES DE BASE (1999)**	**Resultats 2000**	**Objectif 2001**	**Resultats annuel 2001**	
4	Taux de vaccination complète (%)	CAP, Mini-CAP	40.6 (EDS 96)	37	55%	58.05	Les actions menées par PROSAF à Banikoara n'ont pas encore influencé significativement les taux de couverture (BNK: 53,23%; BEMB:71,30; SINENDE 51,92%; N'DALI 51,92).
11	Score de gestion de la logistique des produits de santé familiale	SPED/DDSP SSF/DDSP MCZS	nd	Perf: 33.6; Sust: 58.2	nd	nd	This indicator is no longer used by PROSAF since DELIVER has decided to replace it by a more appropriate one.
12	Indice de Rupture de stock en produits de SF	SNIGS (REMECAR) Rapports de supervision Rapport d'activités de points de distribution	45 (EQGSS 99	13.8	60	40.71	During the 3rd quarter 2001, the stock-out situation seems to have improved. Intensive monitoring and supervision of the service providers trained in logisitics management may have contributed to this correction. Nevertheless, the 1999 level has not been reached. However, since PROSAF's intervention should improve management of the supply and distribution of drugs and contraceptives, a new milestone was developed to measure the effectiveness of those interventions ("50% of the public service delivery points in the Departement of Borgou and Alibori submit correct and timely orders for contraceptives, ORS and other familiy health products, as well as selected essential drugs over previous 3 months") and the indicator will be changed accordingly

Evaluation de Performance Annuelle: Objectifs et Résultats

13	Prévalence des services intégrés de santé familiale (%)	SNIGS Rapports de supervision	12 (EQGSS)	24	50	57	The prevelences for 2000 and 2001 have been measured using data from respectively 4th quarter 2000 and 3rd quarter 2001 within the 94 public health centres and 2 private health clinics (ABPF et OSV Jordan). The objective of 50% set for 2001 has already been exceeded. What is still needed is to improve the quality of the integrated Family Health Services provided.
14	Distribution et services à base communautaire (%)	Rapport d'activités ASBC, COGEC et CCS	nd	10.70	40	30.15	The availability of community-based services (CBS) is increasing slowly because the quantity of kits required is not yet available. For example, CBS in Banikoara are only provided by half of the CBS agents who have sufficient supplies. Mais dès le début du 4ème trimestre 01 plusieurs ASBC de la Zone Bembèrèkè-Sinendé ont été dotés en Kit SBC ce qui a fait monter la distribution à base communautaire de 30% (situation fin septembre01) à 76% . Il reste encore quelques ASBC à équiper dans les deux zones de concentration
15	Visite à domicile par les ASBC (%)	Mini-CAP CAP	nd	10.70	40	14.97	Les ASBC ont été formes et installés dans le dernier trimestre 2000. Certains ont reçu leurs kits début 1er trimestre01 (Banikoara) d'autres au 4ème trimestre01 (Bembèrèkè Sinendé). Les résultats montrent que dans ZS de Banikoara les ASBC mènent effectivement les visites à domicile comparativement aux autres ZS (BNK: 31,56%; BEMB:16,72%; SINENDE 5,57%; N'DALI 4,49%).
VOLET 3: Amélioration des Capacités des Agents de Santé à Offrir des Soins et des Services de							
No.	**INDICATEUR**	**Source de Vérification**	**DONNEES DE BASE (1999)**	**Resultats 2000**	**Objectif 2001**	**Resultats annuel 2001**	**Observations sur les indicateurs et la collecte de données**
16	Indice de Performance du système de supervision (%)	Rapport de supervision	6.7 (EQGSS)	9	30	46	Performance in 2000 and 2001 have been calculated base on respectively 4th quarter 00 and 3rd quarter 01 data. Training of all HZMTs in formative supervision techniques, beginning in 2001, produced fa significant improvement in the performance of the supervision system. The proportion of CCS having benefited at least one supervision visit during the current quarter increased to 46% in september 01 . In the concentration zones, performance is lower because during the 3rd quarter 01 the Bembèrèkè-Sinende HZMT was very involved in the series of training sessions and therefore did not have time to carry out a single formative supervision visit. The objective of 30% for the year has been exceeded. What is still needed is to ensure that during a year period health zones performed four (4) formative supervision visits to each zone health centers.
17	Indice de performance des agents de santé (selon les normes soins prénataux, planification familiale et PCIME)	EQGSS	0	na	CPN:15 PF:15 PCIME:15	na	Nous n'avons aucune donnée sur cet indicateur car la PCIME n'est pas encore mise en œuvre dans le Borgou Alibori. Le Plan de mise en œuvre vient d'être élaboré et sera exécuté en 2002

Evaluation de Performance Annuelle: Objectifs et Résultats

18	Indice de performance des agents de santé en PCIME	Rapports de supervision	0 (EQGSS)	nd	15	nd	La PCIME n'a pas encore été mise en œuvre dans le Borgou/Alibori. Le plan de mise en œuvre vient d'etre élaboré et sera exécuté en 2002
19	Indice de performance des agents de santé en PF (%)	Rapports de supervision	0 (EQGSS)	nd	15	nd	Il n'a pas été possible d'observer un agent de santé en consultation PF au cours des visites de supervision effectuées pendant le 3ème trimestre 2001 juste après les séries de formation des EEZs en technique de supervision formative (2ème trimestre 2001)
20	Indice de performance des agents de santé en CPN (%)	Rapports de supervision	0 (EQGSS)	nd	15	100%	Il n'a pas eu de données avant le 3ème trimestre 2001 puisque la supervision formative n'a été introduite qu'à partir du 2ème trimestre. Au 3ème trimestre 2001 tous les AS observés au cours des supervisions dans les deux zones de concentration ont respecté les normes en CPN (moins de 10% des AS). Ce sont des performances calculées à partir des cotations des actes essentiels des activités de CPN.
21	Indice de performance des agents de santé en Assurance Qualité (%)	Rapports d'activités; Rapports de supervision; SNIGS	0 (EQGSS)	nd	15	52.36	Les équipes AQ ont été constituées et ont démarré leurs activités à partir du 1er trimestre 2001. Déjà à la fin du 2ème trimestre 2001 plus de la moitiée d'entre elles étaient fonctionnelles. Au 3ème trimestre 2001 elles sont devenues toutes fonctionnelles et performantes. C'est pour cette raison que leur performance est à 100% bien que le cycle de résolution de problème dans lequel elles sont engagées soit étalé sur 9 mois et non un trimestre (comme le prévoit un des critères de performance)

VOLET 4: Augmentation de la Demande et de l'Utilisation des Services et Produits de SF/SMI/MST/VIH/SIDA et Mesures Preventives							**Observations sur les indicateurs et la collecte de données**
No.	**INDICATEUR**	**Source de Vérification**	**DONNEES DE BASE (1999)**	**Resultats 2000**	**Objectif 2001**	**Resultats annuel 2001**	
1	Prévalence Cotraceptive pour les méthodes modernes (%)	CAP, Mini-CAP	2.5 (EDS 96)	8.70	9	22.15 (Mini-Cap)	Dans les zones de concentration de PROSAF la prévalence est plus élevée (22 à 25%) que dans la zone témoin 17% (NDali). Ceci serait imputable aux différentes activités menées par le PROSAF: diffusion des messages par les media traditionnels et modernes, offre des SBC. PROSAF devra intensifier ces activités dans les zones de concentration et les étendre dans les autres zones particulièrement à travers les media traditionnels et modernes et la promotion Norplant
2	Couple-Année Protection	Rapports d'activités des CS et des Structures distributrices, SNIGS;	6257	7213	8000	7370	The Couple-years of protection is progressing very slowly because of the difficulties in ensuring a continue and effective supply and distribution of contraceptives.This problem could be resolved if the "Depot regional " is implemented with an integrated supply and distribution of Family Health products including Contraceptives. The objective set for 2001 (8000) is not yet achieved. Public health facilities contributed up to 61.30% of the total CYP 2001 (APBP 38.70%). Norplant contributed almost 10% of the total CYP 2001 and seems to be a promizing method for boosting CYP in Borgou Alibori.

Evaluation de Performance Annuelle: Objectifs et Résultats

3	Prévalence de l'allaitement maternel exclusif (%)	CAP	19 (EDS 96)	52	55	nd	Cet indicateur a été exclu du mini CAP compte tenu de la grande taille de l'échantillonnage et des contraintes qu'imposent la mesure de cet indicateur
5	Taux d'utilisation de la Thérapie de Réhydratation Orale (TRO) (%)	CAP Mini-CAP	29.3 (EDS 96)	15.4	25	50	I n'y a pas de différence sensible entre la zone témoin et la zone d'intervention par rapport à la TRO. PROSAF a mené très peu d'intervention sur le sujet.Pour 2002 la TRO fait partie du paquet des SBC qui sera introduit.
6	Traitement à domicile / Recours aux soins en cas de fièvre (Paludisme) (%)	CAP Mini-CAP	nd	48.5	60	64	La situation est meilleure à Banikoara (79,13%) que dans la zone témoin (66,18%) et à Bembèrèkè(56,85%) Sinende (60,20%) bien que des messages sur ce sujet sont diffusés à la radio dans ces localités. L'intensité et la régularité de la supervision couplées à aux SBC à Banikoara seraient des facteurs favorisant. Ces résultats montrent qu'il faut une synergie d'interventions (messages, supervision et SBC).
22	Connaissance des méthodes modernes de planning familial (%)	CAP Mini-CAP	4.9 (EDS 96)	6	15	27.72	Ce est plus élevé dans les zones de concentration (22,46% à 37,73%) que dans la zone témoin (21,88%). Les média populaires, les messages à la radio, les SBC et les séances éducatives dans les centres de santé ont dû influencé ces résultats
24	Connaissance de la prévention de la diarrhée de l'enfant (%)	CAP Mini-CAP	nd	69	70	48.04	En dehors de Banikoara où le niveau de connaissance est plus élevé (58,66%) Il n'y a pas de différence sensible entre la zone témoin et la zone d'intervention. Pour 2002 la prévention de la diarrhée fera partie du paquet des SBC qui sera introduit
25	Connaissance des symptômes de IST (%)	CAP Mini-CAP	nd	Femmes: 6 Hommes: 23	Femmes: 10 Hommes: 25	Femmes: 38 Hommes: 50.97	Banikoara et Sinendé ont un niveau de connaissance des MST plus élevé qu'à Bembèrèkè et dans la zone témoin. Le chiffre de Banikoara (50%) pourrait s'expliquer par l'existence d'activités SBC et de messages sur la radio au sujet des MST. Il est possible que des ONG aient mené des interventions à Sinendé
26	Connaissance des méthodes pour réduire le risque d'infection au VIH (%)	CAP Mini-CAP	51.8 (EDS 96)	60	65	63.93	Banikoara et Sinendé ont un niveau de connaissance des MST plus élevé qu'à Bembèrèkè et dans la zone témoin. Le chiffre de Banikoara (50%) pourrait s'expliquer par l'existence d'activités SBC et de messages sur la radio au sujet des MST. Il est possible que des ONG aient mené des interventions à Sinendé
27	Connaissance de la prévention du Paludisme (%)	CAP Mini-CAP	nd	55	60	29.27	Banikoara et Sinendé ont un niveau de connaissance des MST plus élevé qu'à Bembèrèkè et dans la zone témoin. Le chiffre de Banikoara (50%) pourrait s'expliquer par l'existence d'activités SBC et de messages sur la radio au sujet des MST. Il est possible que des ONG aient mené des interventions à Sinendé
28	Accès au message en santé (%)	CAP Mini-CAP	nd	Femmes: 44.7 Hommes: 62.3	Femmes: 55 Hommes: 70	Femmes: 42.44 Hommes: 54.79	Ce pourcentage est plus élevé à Banikoara et Bembèrèkè qu' à Sinende et dans la zone témoin. Ceci pourrait s'expliquer par la présence de radio communautaires à Banikoara et Bembèrèkè ayant contracté avec PROSAF

Evaluation de Performance Annuelle: Objectifs et Résultats

VOLET 5: Participation Communautaire							
No.	**INDICATEUR**	**Source de Vérification**	**DONNEES DE BASE (1999)**	**Resultats 2000**	**Objectif 2001**	**Resultats annuel 2001**	**Observations sur les indicateurs et la collecte de données**
7	Indice de performance des COGEC (%)	Rapports d'activités des COGEC, EEZs, CCS (1 fois par trimestre) EQGSS	Borgou: 29 (EQGSS)	Zones: 70	Borgou:35 Zones: 50	Zones: 80 Borgou: nd	Au cours des 3 premiers trimestres de 2001, les performances des COGEC a augmenté et s'est nivelé autour de 80%. La légère baisse au 3ème trimestre s'explique par la période des travaux champêtres qui n'a pas permis à tous de tenir régulièrement les réunions mensuelles.
10	Indice de performance des CVS (Comité Villageois de Santé) (%)	Rapports d'activités des COGEC, CVS (1 fois par trimestre)	nd	nd	25	39	Les données pour le calcul de cet indice ne sont disponibles qu'à partir du 3ème trimestre 2001 parce qu'à cause du démarrage tardif des SBC tous les CVS ne sont pas fonctionnels Le niveau de performance est relativement élevé par rapport à l'objectif qui est de 25% mais il aurait pu être meilleur si les CVS étaient tous fonctionnels

ASBC: Agent de Santé à Base Communautaire
CAP: Enquête de Connaissances, Attitudes et Pratiques
CCS: Complexe Communale de Santé
COGEC: Comité de Gestion de la Commune
DDSP: Direction Départementale de Santé Publique
EEZS: Equipe d'Encadrement de Zone Sanitaire
EQGSS: Evaluation de la Qualité de Gestion du Système Sanitaire
SDPHL: Service Départemental des Pharmacies et Laboratoires
SEPD: Service des Etudes, Planification et Documentation
SNIGS: Système National d'Information sur la Gestion Sanitaire
SSF: Service de Santé Familiale

* Ces résultats ont été obtenus à partir du mini CAP. Il est difficile de les comparer à ceux du CAP 2000 car bien que la méthode d'échantillonnage est la même dans les deux études, les tailles des échantillons n'ont pas été calculées de la même façon.

ANNEX 2

Primary Accomplishments According to USAID Intermediate Results

PROSAF Primary Accomplishments According to USAID Health Intermediate Results

IR 1: Improved Policy Environment	IR 2: Increased Access to Family Health Services and Products	IR 3: Improved Quality of Family Health Management and HIV/AIDS Prevention Services	IR 4: Increased Demand for and Practices Supporting Use of Family Health Services and Products and HIV/AIDS Prevention Measures
• Draft plan to improve DDSP and HZMT management capabilities developed and shared with DDSP	• 85 health workers trained to use family health product management tools	• DDSP and all department heads familiarized with Quality Assurance approach centered around DDSP roles and functions	Adoption and implementation of BCC strategic plan
Trainer's manual on HZMT supervision adopted, along with its template, as a model for other CADZS training modules	26 health centers equipped with medico-technical equipment and began providing the Minimum Package of Family Health Services	40 rapid problem solving teams formed in Banikoara and Bembèrèkè/Sinendé health zones	Qualitative study of behaviors related to the low level of prenatal consultation, child vaccination and the use of contraceptives
Health workers from 21 CCSs coached in conducting mid-course reviews of their budget action plans	Technical and financial feasibility study conducted for the departmental family health product warehouse; funding commitments obtained from donors	Initiation of emergency obstetrical and neonatal care protocols	Development of 27 counseling cards, four brochures, and two posters as educational material for malaria prevention
PROSAF community health worker curriculum adopted as the model for the national curriculum	Family health product stock created in the Banikoara health zone	Training of health workers in 23 CCSs to use FHS protocols and ten mentors to supervise these health workers	Training of 50 health and radio staff in the Borgou/Alibori on the "Role of radio in health promotion" and techniques for development and production of effective spots
Development of IMCI implementation plan (2001-2002)	350 CBSAs in the concentration and non-concentration zones provided with minimal equipment	Training of 22 health workers in contraceptive technology in two health zones	Assessment of activities and development of a program to broadcast family health messages over the radio in the

IR 1: Improved Policy Environment	IR 2: Increased Access to Family Health Services and Products	IR 3: Improved Quality of Family Health Management and HIV/AIDS Prevention Services	IR 4: Increased Demand for and Practices Supporting Use of Family Health Services and Products and HIV/AIDS Prevention Measures
			Borgou/Alibori
Formation of departmental training team and development of training plan	Community-based services introduced and strengthened in the concentration zones	Training of nine mentors and 22 health workers in infection prevention in Banikoara health zone	Dissemination of messages on family planning and ways to control childhood illnesses via popular and traditional media
Midpoint review of 2001 COGEC action plans and budget		Formation and monitoring of 21 rapid problem solving teams	Pre-testing of two radio serials in French on family planning
		Training of all HZMTs in formative supervision techniques	Training of CVS and Local Volunteer Committee (CLV) members in their roles and responsibilities, and conduct of effective meetings
		Involvement of COGECs and Village Health Committees (CVSs) in team-based rapid problem solving process at CCS level	Training of COGEC and COGES members in roles and responsibilities and in conducting effective meetings

ANNEX 3

Management Capacity Development Plan Outline

PROSAF'S MANAGEMENT CAPACITY DEVELOPMENT PLAN FOR HEALTH SYSTEMS MANAGERS

1. BACKGROUND

2. OBJECTIVES

3. STRATEGY

3.1. IMPROVING RESOURCE UTILIZATION
3.2. MASTERING THE MANAGEMENT CYCLE
3.3. FOCUSING ON PRIORITY MANAGEMENT SUPPORT SYSTEMS
3.4. FOCUSING ON MANAGERS AT DECENTRALIZED LEVELS (ZONES AND DEPARTMENTS)
3.5. APPLYING QUALITY ASSURANCE PRINCIPLES
3.6. APPLYING A COACHING MODEL OF CAPACITY DEVELOPMENT

4. IMPLEMENTATION PLAN

4.1. PROGRESS TO DATE
4.2. WORK PLAN FOR YEARS 3 AND 4

5. MONITORING AND EVALUATION PLAN

6. ANNEXES

6.1. ANNEX A: SELECTED MANAGEMENT CONCEPTS
6.2. ANNEX B: MANAGEMENT SYSTEM DEFINITIONS
6.3. ANNEX C: MONITORING INDICATORS
6.4. ANNEX D: WORKPLAN

ANNEX 4

Scoreboard Indicators

Indicators Proposed for the Monitoring Scoreboard at Each Level

Health Center	Zone	Zone Hospital	Department
Nombre de nouveaux contacts pour soins curatifs par habitant et par an dans l'aire de santé du CCS	Pourcentage de la population géographiquement accès au paquet minimum de prestations de soins curatifs et préventifs	Nombre d'hospitalisation pour 1000 habitants (population de la zone)	Réduction de X% le taux de mortalité maternelle
Couverture en consultation prénatale	Performance des Agents de Santé (Nombre d'interactions client - prestataires conforment aux normes de prestation de la PCIME / nombre d'interactions client prestataires observées)	Pourcentage d'évacuation	Réduction de X% le taux de mortalité infantile
Couverture en accouchements assistés	Nombre de CCS ayant des appareils et équipements nécessaires aux soins de qualité fonctionnels	Taux de létalité maternelle de la zone	Sept zones sanitaires fonctionnelles d'içi l'an 2000 (Critères de fonctionnalité à définir)
Proportion des conduites diagnostiques et thérapeutiques correspondant aux instructions des ordinogrammes Fièvre; Diarrhée;Toux; MST (Hombre de conduites diagnostiques et thérapeutiques correspondant aux instructions des ordinogrammes Fièvre;Diarrhée;Toux; MST / Nbr de de Fièvre;Diarrhée;Toux; MST)	Indice de Performance de l'EEZ (% basé sur 4 critères) • Plan semestriel approuvé ayant un financement et réalisé à 80% • Activités planifiées réalisées à 75% • Carte Sanitaire affichée au mur et mise à jour (chaque centre de santé a reçu au moins une supervision formative de l'EEZ au cours du trimestre précédent)	Taux de léthalité pour les trois grandes affections de l'enfant • Paludisme • Diarrhée IRA	Les besoins en personnel suivant la liste définie par niveau sont satisfaits à 50% d'ici 2000
Disponibilité des médicaments essentiels sentinelles y compris les contraceptifs et SRO ((N x 180) - somme jours rupture de chaque produits) / N x 180	Disponibilité des Médicaments (Nombre de CS sans rupture de stock pour les dix médicaments* essentiels sentinelles pendant la période / Nombre total de CS dans la zone)	Taux de césarienne	100% des médicaments sentinelles par niveau sont disponibles

Health Center	Zone	Zone Hospital	Department
Couverture en DTP3	Couple-année-protection	Incidence des infections post-opératoires	80% des supervisions attendues dont réalisées selon les critères définies
Couverture en vaccination antirougeoleuse	Proportion de CS publics offrant le paquet minimum de services de santé familiale intégrés (PM/SSFI)	Nombre moyen d'examens de laboratoire réalisés par mois (Goutte épaisse; Numération Formule Sanguine; Tx d'hématocrite et hémoblobine; Groupage Sanguin; Glycémie)	75% des activités programmées au niveau de la DDSP/B sont réalisées à la fin de chaque année
	% des CCS offrant les soins pré et postnatals y compris la PF en stratégies avancées	Taux d'adéquation des Pourcentage de fiches de contre référence retournées vers les centres de santé de premiers soins avec les informations requises références	80% des agents sont performants à leur poste selon les critères d'évaluation
		Recette moyenne par cas traité	80% des actuelles communes disposent de CCS conformes d'ici) 2002
		Disponibilité des 9 médicaments vitaux ((N x 180) – somme jours rupture chaque produit) / N x 180 Les 9 méd sont : Ampiciline , Atropine, Diazépam, Péthidine, Ergométrine, Gentamicine, Quinine, Ocytocine, Solutés	90% des ZS présentent une gestion saine constatée par l'audit de la DDSP
		Durée moyenne de séjour	100% des réunions semestrielles prévues avec les ZS pendant lesquelles les décisions sont prises utilisant les données analysées sur SNIGS, Personnel, Formation et supervisons sont tenues
		Taux d'occupation des lits	100% des décisions prises pendant les réunions semestrielles

Health Center	Zone	Zone Hospital	Department
			avec les ZS sont appliquées
			Le programme de suivi/ évaluation est réalisé à 80%
			X% d'AS qui prennent en charge les cas selon Les normes et standards établis
			Réduction de X% la létalité infantile par (palu, malnutrition IRA diarrhée
			50% des privés lucratifs fournissent les rapports d'activités
			100% des formations sanitaires ont amélioré leur taux d'utilisation
			100% des accords de partenariat dont mis en œuvre

ANNEX 5

Summary of Qualitative Research

Résumé de l'Etude Qualitative

L'objectif de cette étude est de recueillir des informations sur les composantes de la santé familiale que sont la consultation prénatale, la vaccination et la planification familiale. Plus précisément, cette étude vise à :

1. Identifier les déterminants des comportements vis-à-vis du faible niveau de consultation prénatale adéquate, vaccination des enfants, et utilisation de contraceptifs, aussi bien que la qualité de l'accueil dans les structures de santé.

2. Faire l'analyse des données et des recommandations pouvant servir à renforcer le travail entrepris par des équipes de résolution rapide de problèmes de PROSAF dans les zones ciblées. (voir Annexe C pour une description de ces équipes)

L'étude a ciblé des hommes et femmes Bariba, Dendi et Peulh vivant dans les communautés de base. Elle s'est déroulée dans la circonscription urbaine de Kandi, et une commune sélectionnée dans chacune des sous-préfectures de Sinendé, Bembèrèkè et Banikoara.

Un total de 48 groupes de discussion dirigés (focus) ont été menés ; 8 sur le thème de la vaccination et l'accueil, 16 sur la planification familiale, et 24 sur la consultation prénatale. Le tableau récapitulatif présenté en Annexe B expose les grandes lignes de l'échantillonnage et des cibles.

En s'appuyant sur d'autres enquêtes qui ont révélé que les taux de vaccination, de consultation prénatale, et d'usage de méthodes modernes de contraception sont faibles, cette étude a approfondi la recherche de solutions à ces problèmes. La question d'accueil dans les structures de santé a été également abordée, car ce problème est l'objet d'expérimentation par les équipes de résolution de problèmes dans les zones sanitaires ciblées par PROSAF.

Malgré le taux très bas d'enfants complètement vaccinés dans les zones enquêtées, les femmes en général reconnaissent la valeur et l'importance de la vaccination. La majorité citent aussi les avantages économiques de la vaccination, en ce qu'elle permet d'éviter des coûts de soins de certaines maladies plus tard. Néanmoins, elles reconnaissent que beaucoup d'enfants ne sont pas vaccinés complètement, les raisons résident dans la négligence, l'ignorance ou l'analphabétisme des mères. D'autres raisons citées sont la crainte d'effets secondaires, les occupations champêtres et ménagères, l'éloignement des femmes du centre de santé, l'insuffisance de moyens financiers, l'inconscience des maris et le mauvais accueil.

Pour remédier à ces obstacles, les femmes insistent sur une fervente sensibilisation par la radio, en mettant l'accent sur les devoirs du mari et les informations sur les effets secondaires. Elles suggèrent d'autres stratégies pour les femmes illettrées, telle que l'entraide mutuelle qui consistent à se rapprocher d'une personne instruite ou d'une autre maman qui partage le même calendrier vaccinal.

En ce qui concerne la consultation prénatale, les femmes, une fois encore, reconnaissent son importance, mais n'y vont pas souvent avant le deuxième trimestre. En général, les populations font allusion au rôle capital de l'homme dans le soutien moral et financier de sa femme vis-à-vis des consultations prénatales. L'absence ou la présence du soutien du mari peut entraver ou encourager la femme dans l'assiduité de ces soins. Par conséquent, les femmes et les hommes suggèrent une sensibilisation accrue des maris sur la CPN. Les composantes de cette sensibilisation sont incluses dans le rapport.

Quant à la planification familiale, l'étude démontre une connaissance notable des méthodes, mais une faible utilisation de ces mêmes méthodes. Les femmes Bariba admettent l'utilisation de certaines méthodes à l'insu de leurs maris, or dans l'ethnie Peulh on constate la non utilisation des services de PF. Les populations expriment un désir d'avoir plus d'informations sur la PF à travers la radio, les causeries et les visites à domicile d'agents de santé ou relais communautaires. Les effets secondaires des contraceptifs et les perturbations du cycle menstruel sont des points d'inquiétude pour les femmes et les hommes.

La dynamique de prise de décisions relatives aux soins de santé et l'affectation des ressources au sein des ménages est complexe et problématique. Par rapport à la vaccination, il ressort dans le milieux Bariba et Dendi que c'est la femme qui décident de la vaccination de l'enfant. Par contre, dans le milieu Peulh, c'est le mari. Quant à la CPN et la PF, le rôle du mari est capital. Pour que les hommes soient mieux informés de ces sujets, il faudrait les cibler lors des campagnes de sensibilisation et les actions de vulgarisation de services à base communautaire. Sans cela, les hommes ne pourront pas contribuer de manière consciente à la prise en charge de la santé de leurs familles.

A presque tous les niveaux, l'accueil est ressorti en tant qu'obstacle majeur dans l'obtention des prestations de services de santé satisfaisantes. L'influence de ce mauvais accueil varie d'une simple frustration de la part des mères à des témoignages de femmes et hommes qui déblatèrent et jurent de ne plus retourner pour des consultations à cause du traitement inhumain dont ils ont été objet dans les structures de santé. Des suggestions des enquêtés sont concrètes, comprenant des actions telles que réduire le temps d'attente, fournir des sièges pour ceux qui attendent, ne pas faire subir aux clientes des corvées tels que le balayage, offrir une CPN complète (voir résultats), et accueillir les clients avec chaleur et respect dans toutes les relations.

La grande majorité des populations réclament plus d'informations et de sensibilisation par des émissions de radio. Les avantages et des atouts de ce canal de communication sont inestimables surtout en zone rurale. La radio est de loin la source préférée de renseignements sur tous les thèmes de santé; ensuite viennent la sensibilisation par voie de causeries et les visites à domicile.